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MENTAL HEALTH IN ALBERTA

Volume II

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PREFACE

Four years have passed since the publication of Volume I of Mental Health in Alberta, A Report on the Alberta Mental Health Study, 1968. Although a second volume was promised at that time, it has not been possible to honor the promise until now. Notwithstanding the passage of time, I considered it worthwhile to complete the undertaking because Volume I represented a highly selective presentation, which the second volume was intended to support. Some of the briefs, which until now have not been published, are regarded as valuable from an historical point of view to anyone interested in mental health developments in Alberta. The brief from the Division of Mental Health is in that category. Others contain facts, ideas and recommendations, which are still useful to planners and policy makers, and they did not receive adequate coverage in the necessarily abbreviated Volume I. The submission from the Alberta Association for Retarded Children is a good example.

In reading Volume II it should be recalled that the briefs were written in 1968, five years ago. There has been a good deal of remedial action in the mental health field since that time and quite a number of the priority recommendations have been implemented or are being acted upon. (Progress since the publication of Volume I will be outlined in Chapter 14).

Another word of caution is required. The summaries, for which I alone am responsible, are often quite short and should be regarded as one reader's view of the essential contents of the original briefs. The same caution applies to the longer presentations, if it is indicated that they have been modified in any way.

I wish to express my appreciation to the Government of Alberta for printing Volume II. I would also like to thank the University of Calgary for granting me leave to complete the assignment.

W. R. N. Blair, Ph.D.

March 1973

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CHAPTER 1

REVIEW

Volume I of Mental Health in Alberta was the outcome of the Alberta Mental Health Study, which was commissioned by the Government of Alberta in January 1968 and completed in February 1969. The Study originated with a White Paper on Human Resources submitted to the Legislature in November 1967 by the Honourable Ernest C. Manning. The White Paper recommended two research studies, aimed at making better use of human talents, one on penology, the second on mental health.

The mental health study made use of twelve task groups (comprising almost 100 professional and lay personnel), outside consultants, research officers, briefs (over 200), public hearings at Grande Prairie, Edmonton, Red Deer, Calgary and Lethbridge, and an open seminar in Calgary where the tentative conclusions of the task groups were presented to the public for discussion before the final report to the Government was written.

The scope of the operation will be apparent from a listing of the task groups and some of the special studies. The task groups examined the following topics: addiction; community facilities for mental health; emotionally disturbed children and adolescents; intellectually and neurologically handicapped children; manpower for mental health, education and training; mental health problems of university students; northern mental health problems; organization and administration of mental health services; pupil personnel services in Alberta schools; relative roles of professional personnel; and research in mental health.

Among the special studies undertaken were the following: patient care in mental hospitals; mental health and the elderly; incidence of mental illness in Alberta; alcoholism problems in Alberta; diagnosis and treatment of mental illness.

Principles emphasized in the report (Volume I) follow:

1. Because of the complexity, urgency and magnitude of mental health problems in the Province, any new system which may be adopted must make full use of available personnel and facilities.
2. Optimum use of these resources, and the need to avoid overlapping and other uneconomic activities, demands that they be designed and organized to function as an integrated system.
3. Early detection and prompt treatment, and early release and effective rehabilitation, are essential if the debilitating and often disabling effects of long stays in hospital are to be avoided. The resources in the community to meet most demands are considerable but they have to be mobilized.

4. Delegation of operational authority to community level is essential to create an integrated mental health service, which will make maximum use of local knowledge, local concern and local resources of all kinds.
5. Persons with mental illness of any kind must receive the same excellence of attention and care, as readily, as efficiently, and with as much concern shown for them as persons with any other kind of illness. In a vast majority of cases, the implication is that they should be treated without dislocation or interruption, from the point of detection through to rehabilitation, within or close to their own community.
6. Departmental responsibility for mental health should be exercised solely through planning, the development and promulgation of policy, establishment and maintenance of standards and the operation of financial controls. In assuming that responsibility it is imperative that the Department treat mental health, organizationally, functionally and financially, as an integral part of general health services.
7. The fact that people make systems and programs in mental health must be recognized. In the creation of a new system and new programs, first priority in plans, action and financial support must go to the recruitment, training and maintenance of the necessary personnel.
8. Because of the lack of scientific knowledge about mental illness, it is essential that a major effort be assigned to research of all kinds and to innovations in treatment and other programs, as suggested by the research findings. Continuous and systematic evaluation of the effectiveness of programs should be considered a normal and necessary function of any progressive mental health organization. (Volume I, p.17-18).

Major conclusions in the report were as follows.

1. A new system should be introduced for the delivery of care to persons classed as "mentally ill" or "disturbed." The system would be based on the principle of early detection and treatment at community level, with avoidance of hospitalization outside the community, if at all possible.
2. a. The effective operation of the following services and personnel were seen as vital to the success of the new delivery system: pupil personnel services in the schools, health units (medical officers of health and public health nurses), welfare agencies (public and voluntary), Alberta Guidance Clinics, family physicians and voluntary organizations, like the V.O.N.

- b. The non-hospital agencies and personnel named in (a), above, were grouped in what was called "the first echelon of service." The second echelon included active treatment general hospitals and special active treatment facilities for children and adolescents, both intended to be short term facilities.
 - c. The third echelon comprised auxiliary hospitals and existing "active treatment" mental hospitals whose role was seen as the continuation of active treatment, specialized in nature, for periods longer than would be provided normally in an active treatment general hospital.
 - d. The fourth echelon of service was to be concerned with terminal care. Nursing and other special homes were in that class.
 - e. The above classification was intended to reflect the objective of providing treatment promptly, at the start of illness or disturbance, as close to the affected person's community as possible and in hospital only when necessary.
3. When hospitalization is indicated, the active treatment general hospital close to the person's home should be the facility chosen for use.
- a. Psychiatric units should be established in all general hospitals of 100 beds or more and a proportion of the beds, related to the population to be served, should be available for the treatment of the mentally ill, disturbed or disordered.
 - b. Such units were reported to be required urgently in Lethbridge and Grande Prairie.
4. A major reorganization of mental health services at all levels was considered essential. Proposals included:
- a. The organization of the Department of Public Health on functional lines (e.g. Plans, Research, Programs, Personnel Development, Finance, Facilities) with mental health an integral part of all health concerns.
 - b. The introduction of a mechanism for the coordination of health and the health-related concerns of welfare, law, youth and education at the senior level of Government.
 - c. Decentralization of control over the operation of mental health facilities and programs to community level, with the Government retaining control over plans, policies, standards and finance. The decentralization would extend to the mental hospitals, clinics and similar units.

- d. The regional organization of services with regional councils providing necessary coordination of facilities and programs, e.g. general hospitals, auxiliary hospitals, guidance clinics, health units, alcoholism clinics, welfare units.
 - e. The integration of like facilities and programs "under one roof" (e.g. health units and clinics and, possibly welfare units) to avoid overlaps in services and wasteful use of professional people.
5. The Provincial mental hospitals were reported to be essential parts of the new delivery system.
- a. The role of two of them, Ponoka and Oliver, would be changed, however, to emphasize active treatment in contrast with the largely custodial care, to which they were limited, by the size and nature of their patient population and their over-taxed staff.
 - b. It was urged that the number of patients be reduced substantially through: release to nursing, boarding and other homes; and more restrictive admission practices which would necessitate wide-scale use of general hospitals for the treatment of mentally disturbed persons.
 - c. With smaller patient populations it would be possible to have the professional staff function as consultants to family physicians in their region, in addition to being able to conduct active treatment programs in the mental hospitals.
6. The expansion and strengthening of community facilities were considered critical to the success of the new system, and, in particular, to the successful operation of the mental hospitals and general hospitals.
- a. Auxiliary hospitals and nursing homes must be available to avoid committing the short term, active treatment hospitals to long term care.
 - b. Nursing homes, foster and boarding homes, sheltered workshops, half-way houses and rehabilitation programs must be created or expanded to help reduce the number of patients in mental hospitals and to provide similar relief for other hospitals.
7. The number of Alberta Guidance Clinics should be increased to provide at least one in each health region. They also need larger staffs if they are to perform effectively their important function of early detection and treatment at the community level.

8. It was reported that attention should be given to facilities, standards and services in connection with the treatment and care of emotionally disturbed children and neurologically or intellectually handicapped persons. Two specific conclusions will be cited as examples.
 - a. The lack of hospital-based facilities for emotionally disturbed children south of Red Deer was singled out as an urgent problem.
 - b. Training programs for the trainable mentally retarded should be a responsibility of the Department of Education, not the Alberta Association for Retarded Children.
9. The introduction of an active program of recruitment and training of mental health professionals at higher pay scales was reported to be a matter of high priority. A few of the many specific recommendations will be stated now.
 - a. Nursing education should become the responsibility of the Department of Education, instead of Health.
 - b. Grants-in-aid of specialized training for service in mental health were proposed in the case of all professional categories.
 - c. Improved levels of remuneration, competitive with academic settings and private agencies, were proposed for professional classes employed in Provincial mental health facilities.
 - d. Coverage of their services, under the Alberta Health Plan and associated prepaid medical insurance plans, was proposed for psychologists, nurses and social workers.
10. There should be an energetic attempt made at Provincial and local levels to improve pupil personnel services outside the two large cities. Special grants to man the services from the Provincial Government were considered necessary with regional Guidance Clinics providing service in rural areas until the schools can assume the responsibility.
11. Legislation related to mental health should be examined in relation to the new concepts and new delivery system to determine whether any modifications are necessary.
12. Mental health research should be sponsored by the Government on a wide scale. Long standing and important research needs were reported to include these subject areas: incidence, treatment methods, evaluation of current programs, aging. Financial

support was proposed for postgraduate studies and research related to mental health in psychiatry, psychology, sociology, anthropology and social welfare, in particular.

The above review is selective, of necessity, because Volume I contained 189 recommendations. However, it will provide a link with that volume and it will also serve as background for Chapter 14, a report on progress achieved since 1969.

CHAPTER 2

REPORT OF THE DIVISION OF MENTAL HEALTH
Department of Health, Province of Alberta
(Prepared for Alberta Mental Health Study, July 1968.)

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(NOTE: This is a shortened version of the original report. Copies of Acts, referred to in the report, are available elsewhere. Statistical data have been summarized and integrated with the text of the report.

W.R.N.B.).

AN OVERVIEW, 1919-1967

The material which follows is a short history of developments in the mental health program of Alberta's Department of Health from 1919 to 1967.

The following people were prominent in those developments. Dr. C. A. Baragar was appointed Commissioner of Mental Institutions and Director of Mental Health from September 1930, when the position was created, until his death in 1936. Dr. Baragar had been Medical Superintendent of Brandon Mental Hospital before he assumed the appointment. The Division of Mental Health was established in 1931 early in his term of office.

Following Dr. Baragar's death, Dr. R. R. MacLean was Acting Director and General Medical Superintendent until he became Director in 1948. The designation "Commissioner of Mental Health" was dropped at that time.

He was followed as Director in 1965 by Dr. T. C. Michie who retired in 1966, to be succeeded by Dr. A. R. Schrag, who had been Assistant Director from October 1964. Dr. F. J. Edwards became Assistant Director in October 1966.

The Honourable George Hoadley, who was Minister of Health in 1930, was succeeded in 1935 by the Honourable Dr. W. W. Cross, who remained in office until his retirement in September 1957. The present Minister (1968), the Honourable Dr. J. Donovan Ross, succeeded Dr. Cross. The Deputy Ministers from 1927 were Dr. M. R. Bow, 1927 to 1951; Dr. A. Somerville, 1952 to 1961; Dr. M. G. McCallum, 1961 to 1967; and Dr. P. B. Rose from October, 1967.

Alberta became a province in 1905. Before that time its area was under the control of the Northwest Territories administration. On September 1, 1905, public health services became the responsibility of the Department of Agriculture of the newly formed province and so remained until January 1918. Then the services were transferred to the Department of the Provincial Secretary. In August 1918, they were again transferred to the Department of Municipal Affairs. In 1919 the Department of Public Health Act was passed and the Honourable A. G. MacKay became Alberta's first Minister of Health. Alberta was the second province in Canada to establish a ministry of health and the ministry was the second to be established in the British Empire.

Persons requiring mental hospital treatment in the Alberta territory, up to 1911, were sent to the Brandon Mental Hospital, Manitoba. The present Alberta Hospital, Ponoka, was opened on July 4, 1911, and 164 patients from Alberta were transferred to it from Brandon. During the last half of 1911 an additional 52 patients were admitted from Alberta.

The present Alberta Hospital, Edmonton, opened in 1923 for male patients requiring continuing care. These patients were transferred from other provincial mental institutions, mainly from the hospital at Ponoka.

The Provincial Training School, Red Deer, now the Alberta School Hospital, Red Deer, was opened in 1923 for the training and care of mental defectives. Patients from a home originally established in Edmonton were transferred to Red Deer, and the home in Edmonton closed.

The Provincial Auxiliary Mental Hospital in Claresholm was opened in 1933, and one in Raymond in 1939, for female patients requiring continuing care. These institutions are now called the Alberta Hospital, Claresholm, and the Alberta Hospital, Raymond, respectively.

Rosehaven at Camrose, was opened in 1947, for older male and female patients, many of whom are senile and require continuing care. Most of these patients are 65 to 70 years of age and older.

The Alberta Guidance Clinics were started first in 1929 as Mental Hygiene and Mental Health Clinics. These became known a little later as Provincial Guidance Clinics, and continued under that name until they became Alberta Guidance Clinics, under "The Mental Health Act" of January 1, 1965.

Deerhome, a specially constructed institution for adult mental defectives, was opened at Red Deer on January 8, 1958. The great majority of patients in Deerhome were transferred from other mental institutions in the Province. There were 335 patients in residence on December 31, 1958, 175 men and 160 women. Deerhome is situated adjacent to the Alberta School Hospital but has its own grounds of some 28 acres. Additions were constructed since 1958 and it now has a patient population of 1,228, made up of 682 men and 546 women (December 31, 1967).

A Psychopathic Ward, University of Alberta Hospital, was opened on January 29, 1931, to provide accommodation for 16 patients, with Dr. C. A. Baragar as Director. The admission, care and control of patients was provided for by "The Mental Diseases Amendment Act," 1931. The Director was appointed by the Lieutenant-Governor in Council, and the service was in effect a part of the mental hospital service of the Province.

The ward was to provide for the care and treatment of early cases of mental disorder, the observation and treatment of patients who might be transferred to other institutions later, the observation and treatment of borderline cases, and the examination in consultation of special out-patient cases. It served also as a training centre to a limited degree. During 1931 there were 93 psychiatric patients admitted, 47 men and 46 women. Some 70% were discharged, almost 29% were returned or transferred and 10 remained in the ward at the end of the year.

The Psychopathic Ward, University of Alberta Hospital, was closed March 31, 1933 for economic reasons. The patients were either discharged or transferred to one of the other provincial mental institutions.

Since the early 1950's psychiatric wards have been opened in a number of hospitals in Alberta in the larger cities. These are controlled by the boards of the individual hospitals and are not part of the services provided through the Division of Mental Health.

The admission, discharge, and general governance of provincial mental institution patients is covered largely by "The Mental Health Act" of 1965. Before 1965 there were two acts in operation, "The Mental Diseases Act" of 1907 and "The Mental Defectives Act" of 1919. Both acts have been amended over the years to meet changing requirements. "The Sexual Sterilization Act" currently sets out provisions which apply to persons presented to the Eugenics Board.

ALBERTA HOSPITAL, PONOKA

The Alberta Hospital, Ponoka, was opened as the Provincial Mental Hospital on July 4, 1911. The hospital is situated on a fine site in a countryside with gently rolling hills, on some 2,400 acres of good mixed farming land, about half of which is under cultivation. The hospital has always cared for both male and female patients on an active treatment basis. It was the only provincial institution of its type until 1923 when the Alberta Hospital, Edmonton, was opened for patients requiring continued care.

The Ponoka facility opened with Dr. D. T. Dawson as Medical Superintendent. He was succeeded by Dr. E. H. Cooke in 1916; Dr. C. A. Baragar, then also Commissioner, until March 1932; Dr. George A. Davidson to 1933; and Dr. C. A. Baragar again until 1936; Dr. Randall R. MacLean until 1948, when he became the Director of the Division of Mental Health. Dr. T. C. Michie, who had been Assistant Medical Superintendent, served as Medical Superintendent until 1965 when he became Director of the Division of Mental Health, following Dr. MacLean's retirement. The position of Medical Superintendent of the Alberta Hospital, Ponoka, was then filled by Dr. J. M. Byers, who continues in that capacity. (1968)

The patient population at the Alberta Hospital, Ponoka, steadily increased from 164 in 1911 to 787 by 1921, 501 males and 286 females. The table below shows the number of admissions and discharges and the number registered at December 31 for each of the designated years.

TABLE 1
CHANGES IN PATIENT POPULATION, 1931-67, PONOKA

Year	Admissions	Discharges	Registered Dec. 31
1931	416	314	1,196
1941	557	516	1,637
1946	612	634	1,417
1951	654	594	1,539
1956	685	735	1,572
1961	1,068	929	1,269
1966	1,435	1,483	1,126
1967	1,313	1,412	1,027

"Admissions" include first admissions and re-admissions. "Discharges" include transfers and deaths.

The next table shows the percentages of the patients discharged, based on the time spent in hospital. The figures do not include deaths or transfers. The 1956 figures may be considered representative for previous years.

TABLE 2

PERCENTAGES OF PATIENTS DISCHARGED BASED ON TIME IN HOSPITAL

Year	Under 3 mos.	Under 6 mos.	Under 12 mos.	12 mos. and Over
1956	59%	19%	14%	8%
1961	61%	23%	8%	8%
1966	69%	18%	7%	6%
1967	67%	16%	6%	12%

The Alberta Hospital, Ponoka, began as a large, three-storey brick building with accommodation for both male and female patients, office space and some living accommodation for staff. In addition, the first facilities included other staff quarters and a power house. Since 1911 there have been many changes and additions. Prior to 1920 a three-storey brick building was constructed for female patients. It was remodelled in 1959 and 1960 and re-opened in 1961 as "Lawncrest." Another early ward building was completely renovated in 1954 and opened, as "Parkside," in 1955 to accommodate ninety female patients. A dormitory with space for ninety-six men was built, and opened in 1952, as "East View." Another new dormitory for 100 male patients was opened in 1954 as "Dawn View." In the 1920's two male dormitory buildings, and a second male dining hall were opened. The first male dining hall was built by 1915.

A nurses' residence was constructed in the early 1920's and renovated in 1959-1962. A new nurses' residence was built in 1958-1960. Staff residences were added through the years. Some twenty, many double family residences, had been built by 1930, and some have been added since 1946. New building of any kind was at a minimum from 1931 until after the Second World War. "Jubilee Hall," a new residence for male staff, was completed in 1956. "Hopewell," a new reception and administration building, was opened in 1964.

There has been considerable other construction: a kitchen and bakery (before 1920 with additions in 1960); a building to house plumbing and electrical repair equipment, with quarters for sewing and pressing (by 1920); recreation halls (1930 and 1949 with additions in 1957-1958); a female and staff dining hall (late 1920's); an occupational therapy building (1949); a new laundry (1949); a new firehall and a new building to house the printing plant and the carpenter shop (early 1950's). Other construction has included a cannery, garages, a warehouse, roothouses, a pumphouse, a curling rink, and utility buildings.

In 1964 a foster-home program was established in Calgary, by the Hospital, in conjunction with the Canadian Mental Health Association. That year 24 patients were placed in eight private homes. Three of these patients were returned to hospital, six became self-supporting and fifteen carried on adequately in the community with welfare assistance. In 1966, 57 patients were placed in foster homes in the Calgary, Edmonton and Red Deer areas and in 1967, fifty-one were placed. During 1966 eleven men were placed in "Roberts' House," a half-way house in Calgary, and in 1967 fourteen men were placed there. The Social Service Department assists, too, in placing elderly patients in nursing homes close to relatives, or home areas, when the patients concerned can be cared for in that type of accommodation. In 1966, there were 68 patients so placed, and in 1967, fifty-three. Similar work is carried out through the Alberta Hospital, Edmonton.

In 1960 a "Patients' Band" was organized at the Hospital and it has proved a worthwhile venture.

The Hospital has used an "open-door" policy on about one-half of all wards for the past ten years. The same policy was applied to a lesser degree several years earlier. For example, in 1956, five units of the Hospital operated as open wards successfully. The Alberta Hospital, Edmonton, has pursued a similar policy in this regard.

The diet at the Hospital has always been a matter of concern to the staff. Every effort has been made to maintain staff and equipment at an efficient level, although there have been difficult periods. The cafeteria system was introduced in patients' dining rooms in the early 1930's with dining tables accommodating six to eight persons. Dietitians and appropriate staff have been employed regularly. The Hospital maintains vegetable gardens and the produce is used in season or stored for winter use. For many years a dairy herd on the Hospital's farm supplied milk and the poultry section provided eggs. However, during 1962 the farm operations were phased out, except for the raising of vegetables. Until 1962 part of the meat required, particularly pork, was supplied from the farm. There is close liaison between the dietary and garden staffs making for efficient production and use of vegetable products. The cannery is used to process garden products and fruit for use at the Hospital.

The rated capacity of the Hospital as of April 30, 1968 is 1069 and there were 1006 patients in residence on that date.

ALBERTA HOSPITAL, EDMONTON

The Alberta Hospital, Edmonton, was opened July 1, 1923, as the Provincial Mental Institute, on 1,000 acres, including 900 acres of farm land, located nine miles northeast of Edmonton. The farm was operated by the Provincial Department of Agriculture until 1935 when it was transferred to the Department of Health.

By November 1928, the Hospital consisted of a 2½ storey building used by the administration and as a hospital unit; a second hospital unit; a building for staff, stores, and a bakery; a laundry; power house; greenhouse; and a superintendent's residence. These buildings, and some other residences, were constructed by 1923 or in the following five years.

The first Medical Superintendent was Dr. D. L. Dick, who had been Medical Superintendent of the Hospital for Returned Soldiers, Red Deer. Forty-seven patients from that Hospital were transferred to the Provincial Mental Institute and formed the patient population for 1923. The Institute was for male patients requiring continuing care and functioned in that capacity for a number of years.

During 1924, 89 male patients were transferred from Ponoka and the patient population at the end of the year was 167. By the end of 1928 there were 204 male patients in residence and 257 in 1929, due to transfers from Ponoka.

Dr. D. L. Dick resigned in May 1929, and Dr. Chas. P. Fitzpatrick was his successor, serving until July 1931. Dr. W. J. McAlister replaced him on transfer from the Provincial Training School, Red Deer, where he had been Medical Superintendent, and remained in charge at the Provincial Mental Institute until 1947 when he retired. Dr. A. D. McPherson was the next Medical Superintendent until June 16, 1966, when he retired. The position then was assumed by Dr. J. L. Paterson, the current Medical Superintendent. The name "Provincial Mental Institute" was changed to "Alberta Hospital, Edmonton" in 1965.

The Hospital has expanded continuously but many major changes occurred only in the past twenty years. Staff residences, garage space, and additional utility and storage facilities were built as required. Other major changes comprised: a recreational hall and a firehall (1952); a skating rink (1935 with improvements in 1953); an occupational therapy building (1949 with additions in 1963-64); a nurses' residence (1953 with an addition in 1959); a new laundry building (1959); an administration building (1953); a new admission building (1956); a new tuberculosis unit with a capacity of 196 beds (1952). All tuberculosis patients from other mental institutions were transferred to the new unit.

A new male dormitory was built in 1929, and one in 1938. An addition to an existing male dormitory was made in 1936. An addition to the Administration Building was completed in 1967. It also houses the Out-

Patient Department. A female dormitory building was constructed in 1941, and an additional one in 1948. Connecting corridors were constructed, beginning in 1929. By 1950, there were five such corridors connecting the main wards.

A number of older buildings have been renovated and modernized in recent years and bed capacity has been increased. A new Admission Building of 120 beds is under construction. A modern Geriatric Treatment unit is in the final stages of planning and construction is expected to commence in 1968.

The Provincial Mental Institute remained as an institution for male patients requiring continuing care to the end of 1941, at which time there were 773 male patients registered. In March 1942, 70 female refractory patients, many of whom were mental defectives, were transferred from Ponoka. In 1943 an additional 40 female refractory patients were transferred from Ponoka, and by December 31, 1944, with additional transfers there were 181 female patients, and 890 male patients for a total patient population of 1,071. Until that time first admissions were not numerous because almost all patients were transfers. The number of first admissions was increasing, however, and the Institute was becoming more of an active treatment hospital. The patient population, admissions and discharges for certain years are shown in Table 3.

TABLE 3

CHANGES IN PATIENT POPULATION, 1946-67, EDMONTON

Year	Admissions	Discharges	Registered Dec. 31
1946	103	112	1,239
1956	794	730	1,641
1961	1,268	1,271	1,613
1966	2,094	2,142	1,470
1967	2,259	2,368	1,361

"Admissions" include first admissions, re-admissions, and transfers.
 "Discharges" include transfers and deaths.

In Table 4 the percentages of patients discharged, based on their length of stay in hospital, are given. These figures do not include those who died during the year or were transferred to other institutions. In 1946 (figures not available) the Hospital was still essentially an institution for patients requiring continued care.

TABLE 4

PERCENTAGES OF PATIENTS DISCHARGED BASED ON TIME IN HOSPITAL

Year	Under 3 mos.	Under 6 mos.	Under 9 mos.	9 mos. and over
1946	Figures are not available			
1956	58%	20%	9%	13%
1961	62%	23%	6%	9%
1966	77%	11%	4%	8%
1967	79%	11%	4%	6%

From about 1950, Alberta Hospital, Edmonton, had been receiving a somewhat increasing number of active cases. During 1956 a modern admission building was opened and the Hospital became a full-fledged active treatment institution. At this time, also, the Province was divided into two areas, on the basis of population, for the active treatment of mental diseases. The Alberta Hospital, Ponoka, admitted patients from south of an east-west line roughly passing through Wetaskiwin and Wainwright. The Alberta Hospital, Edmonton, admitted patients north of that line.

The Alberta Hospital, Edmonton, maintained its own dietary and kitchen staff and equipment to late in 1967. Much garden stuff was produced on hospital land and used by the institution. Until 1962, milk was supplied by the dairy herd. No meat or poultry products were provided from this source. In 1962 the farming operations were phased out and milk was obtained from commercial sources. The vegetable gardens continued to be maintained until December 1967 when Versafood Services Limited was engaged to provide meals on a contractual basis. Versafood Services supplies dietitian services, staff, and all food, but works in Hospital space and with Hospital equipment. This new development cannot be fully assessed yet, but the plan has been favorably received by the Hospital.

The rated capacity of the Hospital on April 30, 1968 was 1,065 and there were 1,135 patients in residence at that time.

TREATMENT AND SERVICES: ALBERTA HOSPITALS, PONOKA AND EDMONTON

Treatment procedures at both hospitals have been similar, although the Alberta Hospital, Ponoka, was opened as an active treatment institution in 1911, and the Alberta Hospital, Edmonton, was opened in 1923 for patients requiring continued care. It did not become a fully active treatment institution until 1956.

Hydrotherapy

Hydrotherapy was introduced in the early years of the Alberta Hospital, Ponoka, but was not used extensively at first. Early in 1930 a trained hydrotherapist was engaged and that department was enlarged and reorganized. In 1931 there were fourteen continuous baths on the male wards and eight on the female wards, all in very frequent use. The use of the baths was supplemented by the use of "packs" and "electric cabinets." With the development of the tranquilizers and other forms of therapy, the use of the baths diminished. An Annual Report for 1939 states "Prolonged baths, wet packs, electric cabinets and other forms of hydrotherapy were given daily." A similar report for 1950 states "Hydrotherapy was in constant use." In more recent years this form of treatment has not been used so extensively.

The Alberta Hospital, Edmonton, used hydrotherapy along the same lines.

Dental Services

Regular dental services were started in 1922 at Ponoka, by Dr. George E. Budd of that town, working two days a week at the Hospital. Dr. A. E. Heacock was appointed October 1, 1924 to provide dental services at Ponoka and Edmonton. These services have been steadily expanded to meet the needs of the institutions. Full-time dentists and support staff have been employed for many years.

During 1967 at the Alberta Hospital, Ponoka, dental examinations totalled 2,400 and more than 2,300 procedures were performed. At the Alberta Hospital, Edmonton, for 1967, comparable figures were 2,398 and 2,435.

Occupational Therapy

A "Department of Occupational Therapy" began at the Alberta Hospital, Ponoka, on January 2, 1922, under Miss C. C. Dingman. She resigned October 31, 1923 and the work was then carried on by three teachers whom she had trained. There has been a steady growth in the program at Ponoka and at Edmonton.

The Ponoka program included weaving, basketry, toy-making, tailoring and carpentry.

The Alberta Hospital, Edmonton, did not have an occupational therapy department for the first few years. The value of useful and productive work was kept in mind, however, and "healthful occupation in various departments, and temporary parole" were found helpful.

Gradually larger and more suitable quarters were provided. In 1950 an occupational therapy building was opened at Ponoka, and a similar one at Edmonton, permitting the programs to be expanded.

Recently patient-operated tea rooms have been established at both hospitals. They are located in hospital buildings, employ patients and are run on a profit-sharing basis. The Crescendo Tea Room at the Alberta Hospital, Edmonton has proved very successful and expanded its services in both 1966 and 1967. The tea rooms were set up with the assistance of outside organizations, including the Canadian Mental Health Association, and were preceded by canteen services begun as a part of occupational therapy at both hospitals.

Libraries for patients also were sponsored by the occupational therapists. Some canteen profits were used to buy books. Central libraries are now provided and usually travelling libraries visit all wards periodically.

At first recreational activities were under the supervision of the occupational therapists. After 1946 a separate recreational department was formed although liaison is maintained between the two departments. Local service groups assist with the recreational programs, in the form of transportation, entertainment, and sometimes tickets to outside affairs. Very active programs are maintained at both hospitals in recreational and occupational therapy.

Many articles made in occupational therapy are sold locally, or through bazaars, or exhibits at fairs, and profits assist in supporting patients' programs and activities.

Psychiatric Social Work

The first official appointment was made on July 1, 1922, at the Alberta Hospital, Ponoka, when Mr. T. A. P. Frost was made Provincial Psychiatric Investigator. Much of his time was spent investigating cases in the field and assisting patients and their families. Mr. Stuart K. Jaffray joined the staff in June, 1929, following Mr. Frost. Mr. Jaffray did field investigations, and also began to do psychometric examinations. Mr. Jaffray also worked with the Alberta Guidance Clinics, which started in 1929. He left the service in 1931 to pursue further university studies and was succeeded by Mr. E. J. Kibblewhite. As Guidance Clinics developed they became the centres for psychiatric social work in the field and workers spent less time at Ponoka. In the depression years only a minimum staff was maintained. In the late 1930's it was possible to add two social workers to the Guidance Clinics thus allowing more work to be

done at the Hospital. There was no real expansion in staff or services until after the war.

In the early years there was only one person to do both social work and psychological work at Ponoka. After the war, however, the two services separated and social workers and psychologists were sought. With a further expansion of Guidance Clinic services in 1947, 1948 and succeeding years, positions were established also for social workers and psychologists on the Hospital staff, at Ponoka and Edmonton. There have been difficulties in getting and keeping trained staff in these categories but the need for them was recognized and definite steps were taken to meet the need. Now there are established positions at each hospital.

In 1953, with active participation by Ponoka social workers, an "After-care" group was established in Calgary to assist patients discharged from Ponoka and Edmonton. This service has developed until now there are two psychiatric social workers and a secretary established in suitable accommodation in the Foothills Hospital, and psychiatrists from Ponoka make regular visits to see former patients. This service will be incorporated into the planned Community Mental Health Centre, adjacent to the Foothills Hospital.

Social workers and psychologists at the Ponoka and Edmonton Hospitals take an active part in suitable treatment programs, including psychotherapy, both group and individual. Considerable work with patients and their families is done, including assistance with rehabilitation. They assist as well in public relations and are available to speak to community groups on appropriate topics.

The Alberta Guidance Clinics have always done some follow-up and liaison work for the mental institutions, but this has never been their major task. In earlier years the psychiatrist in charge of each clinic was usually a member of the staff of a mental institution, thus providing a link with the institutions and their patient populations.

Treatment of General Paralysis

In 1924 two new methods of treating General Paralysis were introduced at Ponoka: (1) "By intravenous injections of a new organic preparation of arsenic (tryparsamide)," (2) "By inoculation with the malarial parasite, of which a benign strain (*plasmodium vivax*) was obtained." Twelve cases were treated with tryparsamide, and fourteen with malaria. The results were considered better with malaria, but further use of both methods was considered desirable. The 1925 Annual Report states, "The treatment of General Paralysis of the Insane by inoculation with a benign strain of the malarial parasite is still being carried on ... the results have exceeded expectation, and in the majority of cases the progress of the disease has been arrested with a general improvement in the mental and physical condition." In 1926, 58 cases were treated. "The full course of treatment ... extends over a period of seven months. The complete

remissions amount to approximately 30 per cent, whilst in an equal number improvement continues or the symptoms have been arrested."

The Annual Report for 1931 states, "The use of the malarial treatment as a prophylactic measure in cases of early neurosyphilis, that is, before any mental symptoms had developed, was inaugurated in collaboration with the staff of the Social Hygiene Division. These patients are now admitted by voluntary application, are inoculated, carried through the series of malarial rigors, and as soon after the termination of the malaria as possible are returned to the provincial clinics for the rest of their treatment." Sixty-one cases were treated in 1931.

The use of this treatment increased and, in 1934, 74 were admitted with neurosyphilis, nearly all of whom were given malarial treatment. Treatment by this method continued through 1944. In 1945 malaria and penicillin therapy was used with satisfactory results, and this form of treatment continued to be used to 1951. In the Annual Report for 1951 it is noted that malarial fever therapy was abandoned because of the small number of neurosyphilitics admitted, and "the administration of anti-biotics substituted."

Malarial fever therapy was never used at the Alberta Hospital, Edmonton, cases being transferred to Ponoka for the treatment.

Shock Treatments

Insulin therapy started in 1937 at the Alberta Hospital, Ponoka, and 20 cases of schizophrenia were treated. The results were not too satisfactory, but it was decided to continue such therapy. In 1938 shock treatment using metrazol was started, with some satisfactory results. Twelve were treated in 1938. These forms of treatment continued to be used to 1943 when an electro-shock treatment machine was obtained. This machine replaced insulin and metrazol shock almost entirely. From 1945 electro-shock and insulin shock were used at both Ponoka and Edmonton and are still considered suitable treatment methods. There is definite flexibility in treatment programs. Occupational, recreational, modified insulin and electro-shock therapy and psychotherapy are used as deemed most useful and beneficial in each individual case.

Drugs and Other Methods of Treatment

Those in charge of treatment at the Alberta Hospitals have made a real effort to make suitable use of new drugs, as well as other methods of treatment. The practice has been to give a fair trial to new and promising drugs under carefully controlled conditions, before any more general program was instituted.

Extensive use of the newly-discovered tranquilizing drugs began in 1954 and 1955 with beneficial results. Selected drugs are used with patients in hospital and they are supplied as required to those treated as

out-patients. In this regard, 210 out-patients were seen by staff psychiatrists at the Alberta Hospital, Edmonton, in March, 1968.

Since the early 1950's electroencephalographs have been done as required at both Edmonton and Ponoka. These have proved very useful.

In 1952, sessions in group therapy were instituted at the Alberta Hospital, Edmonton, and at about the same time at Ponoka. In both hospitals considerable emphasis was placed on group therapy with encouraging results. In combination with other forms of therapy, it has resulted in a marked increase in the award of grounds privileges and less destruction of hospital property. About one-half of the wards in each hospital now follow an open-door policy.

During 1949 a limited number of leucotomies were performed on carefully selected patients at the Alberta Hospital, Ponoka. Similar procedures were carried out on small numbers of patients in 1950, 1951 and 1952, with beneficial results in most cases. Over the succeeding years the number given this type of operation has steadily decreased. The procedure is still used occasionally on selected cases.

Beauty parlor facilities have been available, and extensively used, at both Ponoka and Edmonton. The trained staff are helped as circumstances allow by selected patients. This service has proved very helpful in maintaining and increasing feelings of well being among patients.

Forensic Psychiatry

This aspect of psychiatric work has grown steadily, although at times slowly, in Alberta. The psychiatric staffs at Ponoka and Edmonton have worked with the courts and the police on appropriate cases since the hospitals were opened. Cases are remanded to an Alberta Hospital for study, and transfers are made from jails when necessary. There has been a considerable increase in these services over recent years, both through the Alberta Hospitals, and through private professional channels. Cases may be examined with or without remand to a Hospital, and medical staff frequently appear in court in connection with cases examined.

The Alberta Hospital, Edmonton, tends to get more of this type of work now because of its location. It provides a consultative service to the Fort Saskatchewan Gaol for selected cases awaiting trial or serving sentences. Cases awaiting trial, or disposition, in Edmonton also may be examined. During the period 1959 to 1967, inclusive, a yearly average of 169 cases have been remanded to the Alberta Hospital, Edmonton, for examination.

The Alberta Hospital, Ponoka, provides similar services for the southern part of the Province and the Alberta Guidance Clinic, Lethbridge provides a consultative service for the jail located in that City.

THE ALBERTA GUIDANCE CLINICS

The Alberta Guidance Clinics were established in Edmonton and Calgary in 1929 and were called Mental Health or Mental Hygiene Clinics. They were among the first of their kind in Canada. (Earlier clinics were established, before 1920, at the Toronto Juvenile Court by the late Dr. Clarence M. Hincks and at the Out-Patient Department of the Toronto General Hospital by Dr. Hincks and Dr. C. K. Clarke, then Dean of Medicine, University of Toronto.) In Edmonton the early clinics were held in quarters used by the University of Alberta Hospital Out-Patient Department, and in Calgary in quarters used by the Baby and Child Welfare Clinic operated by the Department of Health. The clinic team was composed of a psychiatrist from the staff of one of the mental hospitals or the Commissioner, and one other person, who acted as a combined psychologist-social worker, administered psychological tests, took social histories and did secretarial work.

A title that would be most acceptable to the public was sought and, as the term "guidance" became more popular after the 1930's, the clinics became known as Guidance Clinics and officially as Provincial Guidance Clinics. This title was continued until 1965 when "Alberta Guidance Clinics" became their official name.

Another clinic was set up in Lethbridge in 1930, and one in Medicine Hat in 1933. In the fall of 1934, the first clinic trip was made through the Peace River-Grande Prairie area. Clinics were held at seven centers and 102 new cases were seen in a two-week period. In 1935, a clinic was started in Drumheller. In 1937, clinics were established at Ponoka, High River, and Coleman. The Coleman Clinic was not continued. In 1938, clinics were held at the new centers of Lamont and Vermilion and in 1939, at Red Deer. The Peace River-Grande Prairie clinics were held during a two-week period each fall, although none were held in this area from 1938 to 1949, primarily because of the war.

During the war years clinic services had to be curtailed because of lack of staff. No clinics were held at Medicine Hat and High River from 1942 to 1946, and none at Lethbridge and Drumheller from 1943 to 1946. Most of the clinics closed during the war years were re-opened during 1947. Also the first permanent center with a full-time psychiatrist in charge was established in Calgary September 1, 1947. The staff included two full-time psychiatric social workers and one part-time worker. There had been a full-time psychiatric social worker on staff there since 1938. In the fall of 1948 another full-time clinic was established in Edmonton. In 1949, the clinics in the Peace River area were re-opened. In 1954, a Lethbridge Guidance Clinic was opened on a full-time basis and in 1956, a psychiatrist was appointed to that Clinic. In 1961, a branch of the Lethbridge Clinic was opened in Medicine Hat. In 1963, a branch of the Edmonton Clinic was opened in Grande Prairie.

In 1950 the Province was divided into three zones for Guidance Clinic service. The Northern Zone extended north from an east-west line just south of Wetaskiwin with headquarters at Edmonton. The Southern Zone, which extended south from an east-west line just north of Olds, was served from Calgary. The Central Zone fell between these, roughly from Wetaskiwin on the north to Olds on the south, and was served from Ponoka and Red Deer. These zones are still in effect in general, although the work of the Clinics is now reported on the basis of Calgary and District; Edmonton and District; Lethbridge, Medicine Hat and District; Ponoka and District; and Red Deer and District. The Guidance Clinic in Red Deer functioned on a full-time basis for the first time in 1965, although it had operated with a partial staff for many years. The Alberta Guidance Clinic, Ponoka, still operates with partial staff. In each District, clinic services are provided at key centres either on a scheduled basis, or on request.

There have been increases in staff at the various clinics, particularly during the past few years. Current staff positions are shown in Table 5. At the two largest centers in Edmonton and Calgary summer relief staff may also be employed. A psychiatrist from the Edmonton headquarters visits Grande Prairie on a schedule or as required. Also the psychiatrist at Lethbridge services the Medicine Hat Clinic.

TABLE 5
STAFF POSITIONS AT GUIDANCE CLINICS

Staff Members	Edmonton	Grande Prairie	Calgary	Lethbridge	Medicine Hat	Red Deer
Psychiatrists	9	0	5	1	0	1
Psychologists	13	3	11	3	2	2
Psychiatric Social Workers	15	2	11	3	1	2
Recreational Therapists	1	0	1	0	0	0
Clerical Staff	14	2	12	2	1	2
Totals	52	7	40	9	4	7

The Guidance Clinics in Alberta were established as part of a preventive program in mental health. Dr. C. A. Baragar, Commissioner in the early years, believed in a patient-centered service and his concept continues to be applied. He wrote, "As mental illness is as truly a

state of disease as physical illness, and frequently recoverable, it merits the same efficient scientific and sympathetic medical and nursing care. The greatest obstacle to early and effective treatment is an unkindly general attitude towards those who are unfortunate enough to be sick or crippled in mind. Such an attitude is as unworthy of our civilization as slavery, burning at the stake, or jeering at the hunchback. This attitude is the result of ignorance regarding the causes and nature of mental illness, and will be entirely changed by correct information." Through the years staffs of the clinics have helped greatly to make available correct information about mental illness and to develop more understanding attitudes.

There was little opportunity for any sustained program of psychotherapy in the early years of the clinics. Now, with increases in staff and better physical accommodation, psychotherapy is a regular part of the program and many cases are continued on therapy for varying periods of time, usually with encouraging results.

Table 6 illustrates the growth of clinic services over the years, by showing the number of new cases examined in five year-periods from 1932. Since 1946, the increase has been marked and sustained with the continuing growth of staff and wider coverage of population zones. Further developments in Guidance Clinic services are planned to meet the needs of an expanding population.

TABLE 6
NEW CASES AT GUIDANCE CLINICS, 1929-1966

Years	0 to 5-11	6 to 18-11	19 and over	Totals
1929-31	44	508	96	648
1932-36	155	1,077	587	1,819
1937-41	209	1,168	548	1,925
1942-46	201	761	405	1,367
1947-51	596	4,225	1,182	6,003
1952-56	1,040	5,153	1,314	7,507
1957-61	1,644	6,948	1,290	9,882
1962-66	2,474	11,513	2,837	16,824
Totals	6,363	31,353	8,259	45,975

ALBERTA HOSPITAL, CLARESHOLM

The Alberta Hospital, Claresholm, was opened November 8, 1933, in what had been the Claresholm School of Agriculture, by the Honourable George Hoadley, then Minister of Health. One hundred female patients had been transferred to it from the Alberta Hospital, Ponoka.

Dr. W. I. Valens was appointed Medical Officer, and served in that capacity until February 1937. He was followed by Dr. Morris Carnat, who served until 1940 when he joined the Medical Corps. Dr. Wm. McCallum served as Medical Officer for some months in 1940 and 1941. Since 1941, there has been no resident physician but a local physician has been on call as needed. The Hospital has been under the supervision and direction of the Director of the Mental Health Division. Its function, that of a continued treatment hospital, has been unchanged. Almost all patients are transferred from other Alberta Hospitals.

The Hospital was first called the Provincial Auxiliary Hospital but with the Mental Health Act, January 1, 1965, it became known as the Alberta Hospital, Claresholm. A Matron is in charge of the day-to-day direction and supervision of the institution.

There have been a number of changes at Claresholm since 1960. Almost all of the original buildings have been demolished except for the Nurses' Home, and new buildings have been erected. There are now five new wards, and space is provided for Administration, Occupational Therapy, Beauty Parlor, Laundry, and Kitchen. The patient population increased to 341 (105 males; 236 females) on December 31, 1967. Male patients were accommodated for the first time in 1965, and trained male nurses were added to the staff. During 1967 construction started on the Staff Residence and MacLean Hall, a building for recreational activities and occupational therapy.

Throughout the life of the hospital the need for complete patient care has been recognized, including occupational and recreational activities, and religious services. These have been integrated as an essential re-motivation program. Group and individual therapy are used also. Local community groups entertain and help patients take part in community activities. Religious services are conducted by local clergy and local residents take patients to church services and to other group activities.

The rated capacity of the Hospital on April 30, 1968, was 375 and there were 428 patients in residence on that date.

ALBERTA HOSPITAL, RAYMOND

The Alberta Hospital, Raymond, originally called the Provincial Auxiliary Hospital, was opened in the remodelled School of Agriculture building in February, 1939. This institution was intended to provide continuing care for quiet female patients transferred from other Alberta Hospitals. Dr. M. Carnat, Medical Officer for the Auxiliary Hospital, Claresholm, became Medical Officer for the hospital at Raymond as well. A local physician was on call when Dr. Carnat was absent. During 1939, there were 113 patients transferred to Raymond, two voluntary re-admissions and one re-admission by warrant. On December 31, 1939, there were 104 patients in residence, twelve having been discharged, transferred or died (one). Since 1941, there has not been a Medical Officer in permanent service at the Alberta Hospitals at Raymond or Claresholm. They have been under the direction of the Director of the Mental Health Division as Medical Superintendent, and local physicians have been on call for medical care of patients as required.

The Alberta Hospital, Raymond, has been maintained in its original role. The patient population has remained about the same, and on December 31, 1967, there were 121 in residence. The hospital staff carries out the same type of program with the patients as that followed at the Alberta Hospital, Claresholm. Recreational and occupational activities are well organized and most of the patients take part in them.

The Matron who is in direct day-to-day charge of the hospital does much to create and maintain the interest of the patients in the various programs, assisted by her staff. Re-motivation is an important consideration in many projects undertaken.

Patient capacity of the Hospital is rated at 78 as of April 30, 1968 and there were 80 patients in residence at that time.

ROSEHAVEN, CAMROSE

Rosehaven, an institution for the care of older, usually somewhat senile mental hospital patients, was opened on December 10, 1947. The main three-storey brick building was built as a Normal School before World War I. It was used during World War II as part of a basic training camp for the Army and a number of buildings, including the one used as a hospital, were put up on two sides of it. The main building was renovated for its new role and some of the other buildings were taken over. Almost without exception, the patients have been transferred from other Alberta Hospitals. Rosehaven began with a patient capacity of 200. Late in 1948 there were 187 patients in residence, 105 men and 82 women. The youngest patient was believed to be 66 years old at that time. Rosehaven is under the charge of the Director, Mental Health Division, as Medical Superintendent. Medical care, as required, is supplied by the physicians of a Camrose Medical Clinic.

Since 1947, a number of new buildings and additions have been constructed. Three new dormitories were completed, in 1954, 1955, and 1957. Also, a new root-house, a laundry, carpenter shop, and a greenhouse were constructed.

The type of patient has remained the same since 1947, but the population has increased. There were 467 patients in residence on December 31, 1967, 247 males and 220 females. Because the patients are all in advanced years, there are a number of deaths each year. In 1967 there were 91 deaths from degenerative causes. The average age of death was 83.5 years.

Occupational therapy is carried on for those who can take part. Also recreational activities are initiated and encouraged. Movies are shown, particularly during the winter months, and entertainment is provided for special occasions. Local community groups arrange concerts, local parties or visits, and car rides. Television and radio are available on all wards. Religious services are provided by local clergy and visits are arranged as needed.

Capacity of the Hospital was rated at 442 patients as of April 30, 1968. The Hospital had 475 patients in residence at that time.

ALBERTA SCHOOL HOSPITAL, RED DEER

The Alberta School Hospital opened in Red Deer, as the Provincial Training School, in 1923. Before that time, and in response to urgent demands, the Department of Education in 1918 had remodelled a house on 81st Avenue in Edmonton, and opened it as a home for mentally retarded children. This home soon had 34 patients, children ranging in age from nine years to nineteen years. The home continued under the Department of Education until 1922, when it was transferred to the Department of Health. In the fall of 1922, Dr. W. J. McAlister was appointed Medical Superintendent of the home, and sent to the Eastern United States for several months to study methods of administration and training. During this same period plans were being put into effect to build more suitable accommodation on an appropriate site for the increasing number of mental defectives being reported. The site chosen was that now occupied by the Alberta Hospital, Edmonton. The Department of Health decided in 1923, when accommodation was ready, that a most urgent problem was that of relieving the Alberta Hospital, Ponoka, of a number of patients there requiring continued care. The patients from Ponoka were sent to the new hospital at Edmonton. In the same year, 1923, the mental defectives from the home in Edmonton were sent to Red Deer, and the home was closed.

The three-storey brick building in Red Deer, which became the Provincial Training School in 1923, had been built in 1912 and used as a ladies college. In March, 1918, it was taken over by the Provincial Government to be used as a mental hospital, in part for returned soldiers from World War I. Late in 1921 there were 106 male patients, 38 of whom were returned soldiers. Dr. D. L. Dick was in charge. When the Alberta Hospital, Edmonton opened in July 1923, Dr. Dick became its Medical Superintendent. The mental hospital patients at Red Deer were transferred to Ponoka and Edmonton. Dr. W. J. McAlister became Medical Superintendent of the newly-named School for mental defectives at Red Deer. By 1928 the population of the School had reached 160. Table 7 gives the admissions, discharges, and numbers registered for certain years.

The Alberta School Hospital, known first as the Provincial Training School, has been expanded since World War II. The original site comprised 30 acres and more land was added subsequently, a major portion being the Gaetz Farm. In 1941, "The Gaetz Place," a residence building for 23 boys was opened at the Gaetz Farm. The boys placed there were trained in farm work.

During 1949 three new dormitories and a new Recreation Hall were opened and the old Administration Building was completely renovated. These were followed by a new dormitory for 60 girls (1950); a power house (1951); a firehall (1952); an eight-room school house and a medical staff residence (1953); expansions to laundry and sewing rooms (1953); two new wards, each of 76-bed capacity, and a male staff residence building (1954); a school boys' ward (1955); a start on the Clinical Building, and

major renovations to Wards IV and IX (1956); completion of the Clinical Building and a new Infirmary Ward (1957); an Occupational and Vocational Building, a Sense Training Building, and a 24-bed addition to the male staff residence (1959-60); the first Paediatric Unit (1961) for mental defectives who also had some gross physical abnormality. In 1962, a Paediatric Unit was opened at the Baker Memorial Sanatorium, Calgary. This was followed, in 1964, by a 41-bed unit for similar purposes at the Baker Memorial Sanatorium.

TABLE 7

POPULATION CHANGE, PROVINCIAL TRAINING SCHOOL

Year	Admissions	Discharges	Registered December 31
1931	25	10	190
1941	62	27	251
1951	73	29	395
1956	62	62	698
1961	124	162	718
1966	163	102	922
1967	133	78	977

Dr. W. J. McAlister continued as Medical Superintendent at Red Deer to 1931, when he became Superintendent of the Alberta Hospital, Edmonton. Dr. D. L. McCullough, of the Medical Staff at Alberta Hospital, Ponoka, followed Dr. McAlister until July, 1949, when he retired. Dr. L. J. le Vann became Medical Superintendent in August, 1949, and has served in that capacity except for a period of some ten months in 1951-52.

There are several differences between the active treatment Alberta Hospitals and the Alberta School Hospital, Red Deer. Patients at the School Hospital are mentally defective, not mentally ill; patients come to the School Hospital to be trained, so far as possible, not to be cured of an illness; a patient's stay in the School Hospital is much longer, generally, than in an Alberta Hospital; and activities at the School Hospital are set up to a large degree with training in mind. There are, however, low grade patients who cannot benefit from any educational program and who can take little if any training. The School Hospital operates regular school classes for those who can benefit, and sense training classes for others or for younger patients. Other activities in

and around the institution are used to help prepare the boys and girls to become self-supporting where possible. The farming operations, including the raising of both beef and dairy cattle, hogs and poultry are used for training. Work in the kitchen, dining room, laundry and sewing rooms also constitutes training. Occupational therapy in weaving, leather work, knitting, rug making, basketry and woodwork are both useful and recreational.

Group activities are encouraged for those who can benefit. In this connection there is a strong Parent-School Association at Red Deer that has been most helpful. In 1955, a summer camp site was purchased for the use of School Hospital patients by that Association.

Some patients are allowed to work out, usually on a day basis, under suitable circumstances.

Recreation includes swimming, skating, bowling, table games, picnics, hikes, and summer camps.

The first appointment of a professionally-trained social worker to the staff was made in 1950. There are now two regular positions on staff for social workers. These staff members interview parents whose children are admitted, investigate work placement situations, and provide counselling services to discharged patients as required.

There is a dietitian on staff and efforts are maintained to provide attractive and well balanced meals. The greenhouse facilities on the grounds are of definite help in that regard.

DEERHOME, RED DEER

Deerhome, under construction since 1955, was opened for patients on January 8, 1958. It had been constructed for the custody and care of adult mental defectives. The first patients comprised ten female defectives from the Alberta School Hospital, and twenty-two female defectives from the Alberta Hospital, Ponoka. By the end of 1958 the patient population had increased to 335, 175 males, and 160 females. Only 16 had been admitted directly from the community, the others were transferred from Alberta Hospitals.

New construction at Deerhome since 1958 has included: six new dormitories, an administration building, female staff quarters, male staff quarters, a recreation and therapy building, a storage and machinery building, carpenter shop, greenhouse, several roothouses, an incinerator and a warehouse.

During the first years of its operation the institution was controlled and supervised by the Director of the Division of Mental Health, then Dr. Randall R. MacLean. Dr. T. C. Michie and Dr. A. R. Schrag also functioned in that capacity during their respective terms of office as Director. On July 1, 1967, Dr. J. M. Brown was appointed Medical Superintendent.

Medical care is provided by the physicians on the Parsons Clinic staff, Red Deer. The Director of the Alberta Guidance Clinic, Red Deer, visits once each week as a consultant to assess and treat those patients with psychiatric and emotional problems.

The laboratory at Deerhome carries out routine tests as required. Other tests are made by outside laboratories. Over 9,000 tests were done in 1967.

Dental clinics are held regularly. During 1967 there were 118 clinics for 1,602 patients.

Deerhome has a comprehensive program for occupational therapy and recreation. There are positions for eight Recreational Therapists, and fourteen Occupational Therapists and Occupational Therapy Aides. It is difficult to maintain a full staff. However, the varied programs include: handiwork, walking parties, physical fitness classes, swimming classes (downtown pool), skating in season, bowling, dancing, tennis, badminton, card parties, parties for special occasions, movies and trips outside to special events. Many local groups assist in providing entertainment, recreational equipment and transportation to outside events such as home visits, religious services, and pleasure drives.

Religious services on a non-denominational basis are held weekly at Deerhome, except for July and August. Roman Catholic Mass is held monthly for Roman Catholic and Greek Catholic patients. Members of the clergy also visit patients on request.

An in-service educational program was begun in February 1967. This has been a six-week course for staff members and is designed to cover basic nursing care. One staff member from each ward has been assigned to each course. Five courses were given in 1967 and these are continuing in 1968. A short indoctrination course has been given for new staff members and it is planned to lengthen this course to two weeks.

The patient population has gradually increased as additional accommodation became available. There were 1,228 patients actually in residence on December 31, 1967, 682 men and 546 women. At that time there were 273 men and 179 women, for a total of 452 patients on leave of absence, making a total of 1,680 patients registered at Deerhome. The rated capacity is 1,141 (as of April 30, 1968); on that date there were 1,309 in residence.

A number of patients have been able to work out at selected places of employment under supervision. During 1967, twenty to thirty boys worked out on a daily basis from May to October and 33 boys worked out on a monthly basis for an average of seven months of the year. Some 34 girls worked out on a daily basis in 1967 and nine on a monthly basis. All of these people received a nominal wage. Within Deerhome itself, almost 400 male and female patients assist with routine work in various departments. The occupational therapy aspect of the work is of basic importance, but some form of financial incentive for patients who work at the institution could prove beneficial.

No immediate further expansion of Deerhome is planned, although there is a definite policy to maintain and improve existing facilities.

LINDEN HOUSE, RED DEER

Linden House is situated on the grounds of the Alberta School Hospital, and is also under the direction and supervision of Dr. L. J. le Vann. The unit was organized in 1960 for emotionally disturbed children and adolescents of average or normal general ability, ranging in age from 5 to 14 years, inclusive. It was set up to accommodate fifteen boys and fifteen girls. The patient population has varied from 29 in 1960 and 20 in residence that year on December 31, to a total of 22 during the year 1967, with 10 in residence on December 31. The patient population has included a consistently larger number of boys than of girls. Dr. le Vann states, "It has been our experience over the years that our major admissions have consisted of children who have come from homes of marginal or less socio-economic status. These have included homes where the parents were severely psychoneurotic, insane, alcoholics, as well as families on public assistance." He also states that these children "acquired good habit formation and social acceptability" in a relatively short time at Linden House, in most cases. In many instances they were kept there long after they might have been discharged because a return to their homes would have undone the good work accomplished, and there was no other place to send them. Foster homes and youth hostels for the care of such discharged cases could be one solution to this problem.

Linden House operates as an open-door institution, and there have been very few elopements. The children have a part in governing themselves, and in his 1967 Annual Report, Dr. le Vann writes that "initial programs (are) instituted for each child of individual psycho-therapy and as a child develops greater inter-peer relationships, he is included in bi-weekly sessions of group ethics and the children's weekly parliament."

It is not entirely clear why more boys than girls are admitted to Linden House. One factor may be a somewhat greater tolerance of society to the anti-social conduct of girls.

Many boys and girls attend school in the City of Red Deer, leaving Linden House each morning and returning after school.

Linden House is used as a training area for senior nurses and attendants of Alberta School Hospital. This plan has proved beneficial to both staff and patients in both institutions. The staff members in training spend at least a three-month period at Linden House.

The table below shows the patient population and turn-over at Linden House since it was opened. The "Admissions" include re-admissions and transfers, both minority groups. "Discharges" include transfers, also a minority group.

TABLE 8

PATIENT POPULATION, LINDEN HOUSE, 1960-67

	1960			1961			1962			1963			1964			1965			1966			1967		
	*M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
January 1	0	0	0	14	6	20	15	6	21	14	6	20	12	6	18	12	7	19	13	4	17	11	5	16
Admissions	20	9	29	5	5	10	10	3	13	2	4	6	8	7	15	7	2	9	4	4	8	4	2	6
Discharges	6	3	9	4	5	9	11	3	14	4	4	8	8	6	14	6	5	11	6	3	9	9	3	12
December 31	14	6	20	15	6	21	14	6	20	12	6	18	12	7	19	13	4	17	11	5	16	6	4	10

* Male (M), Female (F), Total (T).

The children at Linden House take part in a variety of recreational and extramural activities, including skiing and tobogganing, picnics and outings to resort areas, occasional trips to more distant places. All of the children attend summer camps. There are trips to the Fire Hall, Court House and other places of interest to them, as opportunity permits.

STAFF TRAINING PROGRAMS

ALBERTA HOSPITAL, PONOKA

No planned training courses were conducted at this hospital from 1911 to 1929. During 1930 Dr. C. A. Baragar, then Commissioner of Mental Health, and senior staff members began a planned course in nursing for both nurses-in-training and attendants. In 1930 and 1931, a short course of instruction was given to all non-graduate nursing personnel. Also in 1930, a selected group of women with high school education commenced lectures in a nursing course with the expectation that approval would be obtained to establish a regular school of nursing, and that affiliation in general nursing would be established. In 1934, the Senate of the University of Alberta and the Registered Nurses Association approved the establishment of a School of Nursing and affiliation was arranged with general hospitals in Edmonton and Calgary (Calgary General, Holy Cross in Calgary, the General, Misericordia, Royal Alexandra and University of Alberta Hospitals in Edmonton). Nursing students, who enrolled in 1930-1931-1932, completed a three-year course and were granted certificates in Psychiatric Nursing.

Since 1934 several training courses have been maintained.

1. Combined Psychiatric and General Nursing Course

The length of this course is four years, two years at the Alberta Hospital, Ponoka, and two years at an affiliated general hospital (the Calgary General Hospital since 1960). Originally the affiliation period was the last 24 months of the course. This has been changed to the 17th to 39th months, and the 40th to 48th months are then spent on a senior term in psychiatric nursing. The course leads to a Diploma in General and Psychiatric Nursing (R.N. and R.P.N.). To 1967, there were 261 graduates, including seven men since 1958. The course itself has changed over the years with more time and emphasis being placed on training in nursing, and less time on service commitments. There has been an increase in the number of instructors, many better prepared than formerly, with improvements in teaching methods. These changes have been reflected in fewer drop outs and better student motivation. Thirty-four graduates have gone on to university degree work, most of them taking further training in the nursing field.

2. Psychiatric Nursing Course

The length of this course is three years, leading to a Diploma in Psychiatric Nursing. The course developed from an attendants' course which commenced in 1930. To 1968 there have been 224 male graduates. Twenty-five women had taken the course in 1933-1934-1935, before approval for the combined course was obtained. Since 1930 there have been many improvements and changes in the course, in the form of more extensive clinical teaching, more time devoted to actual training compared with service duties and improved teaching methods.

3. Post-Basic Course in Psychiatric Nursing

This course was started in 1930 and its main purpose was to help the graduate nurse develop an understanding of nursing the mentally ill. The post-basic students were employed at that time on staff filling graduate nurse positions. The length of the course was one year. This was later changed to six months. The course was improved by better control of clinical experience and better methods of instruction. The students taking the course were no longer placed in staff positions but in student nurse positions, allowing more time for training. Since 1956, basic preparation in psychiatric nursing has been a requirement for those taking the course. A total of 330 have completed the course and received certificates in Psychiatric Nursing.

4. Psychiatric Nursing Affiliation Course

This course of eight weeks is a part of the full training of students enrolled in schools of nursing. The first class was enrolled in 1949. The students come to the Alberta Hospital to gain a better understanding of human relations and behavior, and of the psychiatric aspects of nursing. To December, 1967, 2,648 nursing students had completed the course.

University school nursing students also have one month of field work at the Alberta Hospital and students from the Alberta School Hospital spend a day here. In-service orientation courses are also given for various groups of staff personnel.

ALBERTA HOSPITAL, EDMONTON

1. Three Year Psychiatric Nursing Program

This program commenced in 1945 and is similar to that given at the Alberta Hospital, Ponoka. Since the course began, there have been 355 graduates, made up of 186 men and 169 women.

2. Psychiatric Nursing Affiliation Program

This eight week course commenced in May, 1956. It corresponds with the "affiliation course" given at the Alberta Hospital, Ponoka. 2,458 students completed the course by the end of 1967.

3. Public Health Nurses - Psychiatric Experience

This course was arranged for graduate nurses who were taking Public Health Nursing at the University of Alberta. It was a two weeks' course started in May, 1959, and discontinued in 1966, because of changes in public health nursing and basic preparation for that field. Ninety-five students completed the course.

4. Refresher Course for Psychiatric Graduate Nurses

The first course began January 15, 1968, and finished April 15, 1968. The purpose of the "course is to upgrade the practice of inactive graduate nurses and/or nurses who received their education some years ago." Seven nurses completed this first course and it will be repeated as the need arises.

TABLE 9

NURSING TRAINING PROGRAMS AT ALBERTA HOSPITALS, PONOKA AND EDMONTON
(Figures to December 31, 1967, unless otherwise noted)

Training Course	Alberta Hospital, Ponoka			Alberta Hospital, Edmonton		
	Course Began	Male	Female Total	Course Began	Male	Female Total
Combined Psychiatric and General Nursing Four Year Course	1934	7	254 261			(never given)
Psychiatric Nursing Three Year Course	1930	224	25 249	1945	186	169 355
Post Basic Course in Psychiatric Nursing Six Months Course	1930	0	330 330			(never given)
Psychiatric Nursing Affiliation Course Eight Week Course	1948	0	2648 2648	1956	0	2458 2458
Psychiatric Experience for Public Health Nurses Two Week Course		(never given)		1959 (Course discontinued after 1965)	0	95 95
Refresher Course for Graduate Psychiatric Nurses Three Months Course	1968	(To be given as required)		1968 (First course given Jan. 15 to April 15. To be repeated as required.)	0 7	7 7
Totals		231	3257 3488		186	2729 2915

IN-SERVICE TRAINING IN SUPERVISORY SKILLS

Arrangements were completed late in 1967 with the Personnel Administration Office, Government of Alberta, to have a number of 20-hour courses in supervisory skills given at the Alberta Hospitals at Ponoka and Edmonton by the Personnel Supervisor. These courses were given as in-service training and were open to supervisory personnel from any section of the hospital service. Sixty-four staff members at the Alberta Hospital, Edmonton, and 122 at the Alberta Hospital, Ponoka, took the courses in 1967-68. It is expected that similar courses will be available in the future, at these and other Department of Health institutions.

ALBERTA SCHOOL HOSPITAL, RED DEER

The records indicate that some training courses for nurses were given in the 1930's, although the details are unavailable. One nurse was graduated in 1936. During the period 1941 to 1944, sixteen people graduated in Mental Deficiency Nursing, of whom three were still employed by the School Hospital in April, 1968. The training program covers three years of work in many of the same basic courses as those given students in psychiatric nursing, or schools of nursing. From 1945 to 1954, fifty-five graduated in Mental Deficiency Nursing. From 1955 to 1967 the number of graduates are shown in Table 10.

TABLE 10
GRADUATES IN MENTAL DEFICIENCY NURSING

	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967
Male					3	7	9	9	9	4	8	2	0
Female					0	10	8	10	11	14	8	17	10
Totals	13	20	12	12	3	17	17	19	20	18	16	19	10

In the period 1966-1968 a gradual conversion from a three-year to a two-year course has been made. This two-year course should be fully operational in 1968-69. The number of hours of lectures has been increased and there have been changes in content.

During each summer a short orientation course is given to summer relief students. It is planned to expand this course to provide basic training for a non-student body of permanent workers on a year round basis.

The courses given at the Alberta School Hospital have led to a high standard of care at the Hospital. As well, they have provided many trained staff members for Deerhome. It is believed that some type of affiliation in the training of staff with other Alberta Hospitals would be helpful and in the better interest of staff and patients.

TRAINING COURSE GRANTS

The attached table and graphs show the number of physicians, nurses, psychologists, social workers, occupational therapists and others who have received and used training grants. These grants have proven very helpful and are given through the Department of Health. The courses were taken outside the mental health institutions of the Province.

TABLE 11

TRAINING COURSE GRANTS

Classification	Fiscal Years			
	1948-49 1952-53	1953-54 1957-58	1958-59 1962-63	1963-64 1967-68
<u>PHYSICIANS</u>				
Postgraduate Training in Psychiatry	5	3	19	14
Refresher Course	2			
Mental Hospital Institute	1	1		
Special Course	2	1	2	1
Psychiatry and Neurology		1		
Mental Health Short Course		7	2	
Tour Mental Defectives Institutions		1		
	10	14	23	15
<u>NURSES</u>				
Mental Hygiene Course	2		1	
Teaching and Supervision	1	1	3	11
Psychiatric Nursing	1	5	1	3*
Neurological Nursing	1			
Nursing Unit Administration			3	
	5	6	8	14
<u>PSYCHOLOGISTS</u>				
B.A. in Psychology				3
M.A. in Psychology		1	8	4
Ph.D. in Psychology			2	2
	0	1	10	9
<u>SOCIAL WORKERS</u>				
B.S.W.	1	4	5	17
M.S.W.			8	1
	1	4	13	18
<u>OCCUPATIONAL THERAPISTS</u>				
Course in Occupational Therapy		7	6	10
	0	7	6	10
<u>TEACHERS</u>				
Course in Mental Hygiene	1	3	1	
Teaching Mentally Retarded		1	1	
	1	4	2	0
<u>OTHERS</u>				
Course in Electro-Encephalography		1		
	0	1	0	0
Totals	17	37	62	66

Grand Total 182

*(1 B.A.)

THE EUGENICS BOARD

The Sexual Sterilization Act for the Province of Alberta was passed in 1928. Quotations in this section are from the Act. It set up a "Board" of four members appointed by the Lieutenant Governor in Council to administer it. The Act states, "Two members of the Board shall be medical practitioners appointed by the Senate of the University of Alberta, and the Council of the College of Physicians and Surgeons, respectively, and two members shall be persons, other than medical practitioners, appointed by the Lieutenant Governor in Council." This Board is usually referred to as the Eugenics Board.

The medical superintendent or other person in charge of a mental hospital may present a patient whom it is proposed to discharge, to the Board. Also, according to the Act, a medical practitioner in charge of a "mental hygiene clinic may cause a mentally defective person who has been under treatment or observation at such a clinic to be examined by or in the presence of the Board."

There are four main groups of cases the Board may examine. These are psychotic (mentally ill) persons; mentally defective persons; those "suffering from neurosyphilis with deterioration not amounting to psychosis but not responsive to treatment," or "suffering from epilepsy with psychosis or mental deterioration"; and those "suffering from Huntington's Chorea." In such cases the Board must be unanimous in its decision that the power of procreation if exercised would result in the transmission of mental disease, or mental disability or deficiency, or would "involve the risk of mental injury either to such person or to his progeny."

The consent of the person whose case is being considered must be obtained, except for mentally defective persons. In situations where the person whose case is being considered is still psychotic and not capable of giving valid consent, the consent of the husband, or wife or, if unmarried, a parent or guardian is required.

The Eugenics Board may direct in writing the performance of a sexual sterilization operation when the conditions noted above have been met. The Board appoints surgeons to carry out the operations, two in the Province, and issues its written directives only to them. No other medical practitioner may perform such operations under the Board's direction. The first of these operations was performed in Alberta in 1929. Since then, to December 31, 1967, a total of 4,430 cases have been passed by the Board, 2,064 male and 2,366 female. A total of 2,572 cases have been operated on, 1,082 male and 1,490 female. The operations are performed at an Alberta Hospital, with few exceptions.

The Board meets for the consideration of cases several times each year, usually at an Alberta Hospital. In 1967 there were 10 such meetings, held at the Alberta Hospital, Edmonton; the Alberta Hospital, Ponoka; the Alberta School Hospital, Red Deer; and Deerhome, Red Deer.

The Eugenics Board has been most conscientious in the discharge of its duties. It has given careful consideration to all presentations made to it and dealt with each in a suitable manner. There have been a number of requests to terminate pregnancy, considered by the individuals concerned to be undesirable for general or specific health reasons. These requests cannot be granted because the powers of the Board under The Sexual Sterilization Act do not give it authority to direct such termination.

Tables giving a summary of the work of the Board since it was formed and to December 31, 1967, are given below.

TABLE 12
CASES PRESENTED AND PASSED
(To December 31, 1967)

Years	Yearly Totals			Cumulative Totals		
	Male	Female	Totals	Male	Female	Totals
1929-33	87	201	288	87	201	288
1934-38	557	438	995	644	639	1283
1939-43	339	299	638	983	938	1921
1944-48	237	311	548	1220	1249	2469
1949-53	187	239	426	1407	1488	2895
1954-58	302	275	577	1709	1763	3472
1959	32	62	94	1741	1825	3566
1960	37	65	102	1778	1890	3668
1961	44	75	119	1822	1965	3787
1962	48	71	119	1870	2036	3906
1963	45	80	125	1915	2116	4031
1964	43	63	106	1958	2179	4137
1965	28	53	81	1986	2232	4218
1966	51	79	130	2037	2311	4348
1967	27	55	82	2064	2366	4430

TABLE 13
OPERATIONS ONLY
(To December 31, 1967)

Years	Yearly Totals			Cumulative Totals		
	Male	Female	Totals	Male	Female	Totals
1929-33	48	158	206	48	158	206
1934-38	198	240	438	246	398	644
1939-43	122	151	273	368	549	917
1944-48	87	124	211	455	673	1128
1949-53	84	162	246	539	835	1374
1954-58	207	160	367	746	995	1741
1959	40	50	90	786	1045	1831
1960	21	48	69	807	1093	1900
1961	53	52	105	860	1145	2005
1962	33	65	98	893	1210	2103
1963	31	61	92	924	1271	2195
1964	37	44	81	961	1315	2276
1965	45	47	92	1006	1362	2368
1966	42	65	107	1048	1427	2475
1967	34	63	97	1082	1490	2572

THE BOARD OF VISITORS

The Minister of Health appointed the first Board of Visitors in 1925 to inspect and report on all institutions in the Province operated by the Department of Health. This Board carried out thorough inspections of these institutions annually and reported to the Minister, until the Board to administer The Sexual Sterilization Act of 1928 was appointed. The Board to administer this Act, usually called the Eugenics Board, also functioned as a Board of Visitors inspecting institutions and clinics operated by the Department of Health, with particular reference to those under the Division of Mental Health. This plan continued into the late 1950's. In 1960 a separate and distinct Board of Visitors was again created consisting of three members. Its "Terms of Reference" as attached to its 1961 Report were:

"1. To investigate annually and submit a report to the Minister of Health for tabling in the Legislature on their findings as to the care, treatment and rehabilitation and general attitudes of patients and the general attitude of staff in all institutions administered by the Department of Health.

"2. To investigate and report on the programs for prevention of disease in these various fields.

"3. To submit a report to the Minister regarding such recommendations for improvement of conditions that they feel are desirable."

Reports were submitted in 1960, 1961, 1962 and 1963. Later it was regretted that two members of the Board found it necessary to withdraw their services. In November, 1966, another Board of Visitors consisting of four members was appointed, including the third member of the previous Board. Reports were prepared and submitted for 1966 and 1967. The general "Terms of Reference" remain unchanged. The reports of the Board of Visitors are tabled in the Legislature. The recommendations of the Board are always given careful consideration, and in many cases are implemented.

MENTAL HEALTH SURVEYS IN ALBERTA

The Department of Health has demonstrated its awareness of the need for study and improvement in its mental health institutions in a number of ways including the surveys it has authorized.

The first "Mental Hygiene Survey of the Province of Alberta" was made in 1921 by Professor D. G. Revell at the request of the Provincial Cabinet. The survey of Dr. Revell was carried out in October and November, 1921, under the auspices of the Canadian National Committee for Mental Hygiene, a national organization formed a few years previously.

The purpose of this survey was stated as to "obtain information concerning the mentally handicapped of Alberta, so that light may be thrown on such questions as the following:

- (1) Existing facilities for the care of the insane.
- (2) Institutional provision for mental defectives.
- (3) The problem of mental deficiency in public schools and steps that have been taken to deal with the situation.
- (4) Mental abnormality as a factor in delinquency.
- (5) The relationship that exists between mental abnormality and such social problems as illegitimacy, prostitution, and dependency.
- (6) The effect of immigration on the problem of mental abnormality in Alberta.
- (7) Urgent mental hygiene needs in Alberta in connection with prevention, diagnosis, early treatment, control and follow-up supervision of mental abnormals."

Dr. Revell visited the mental institutions in the province, a number of privately operated centres, hospitals, the provincial jails, and a number of public schools. He prepared a lengthy report for submission to the Cabinet, which received careful study.

Another survey was carried out late in 1928 by Dr. C. M. Hincks and Dr. C. B. Farrar who had been appointed as Commissioners by the Provincial Cabinet to make the investigation. The Commissioners were to investigate the Provincial Training School, Red Deer, (Alberta School Hospital), the Provincial Mental Institute, Oliver, (Alberta Hospital, Edmonton), and the Provincial Mental Hospital, Ponoka, (Alberta Hospital, Ponoka). Their report was submitted to the Lieutenant-Governor of Alberta in January, 1929. The terms of reference for this survey covered in a broad way all phases of the operations of the institutions named. Again a lengthy report was submitted, given thorough study and many of its recommendations acted upon.

On September 19, 1947, an Order in Council was passed by the Government of Alberta authorizing Dr. Clarence M. Hincks, General Director of the National Committee for Mental Hygiene (Canada), "to make a general survey of the conditions existing in and the services rendered to the

mentally ill and mentally defective by the mental institutions of the Province, and by the Mental Hygiene Clinics in the Province." This survey was carried out by Dr. Hincks in late 1947 and a comprehensive report submitted. This report was prepared in printed form in 1948 by the King's Printer and received rather wide distribution. Again, many of the recommendations made were implemented by the Health Department and other long range recommendations have been put into effect as conditions warranted.

THE PRESENT

The following information comes from the Division of Mental Health Annual Report for 1967.

Division of Mental Health

Administration

The Division of Mental Health concerns itself with the provision of treatment and preventive services for mentally disordered persons. Treatment and care of the mentally ill was provided by two active treatment hospitals, two continued care hospitals, and a geriatric hospital. There is a unit for emotionally disturbed children, a school hospital for retarded children admitted under the age of 16, and a hospital for the care and rehabilitation of the adult mental retardate.

Because of changes in the physical facilities, new bed capacities were established and are as follows:

	<u>Capacity</u>	<u>Patients In</u>
ACUTE MENTAL HOSPITALS		
Alberta Hospital, Edmonton	1,069	960
Alberta Hospital, Ponoka	1,065	1,141
CONTINUED TREATMENT HOSPITALS		
Alberta Hospital, Claresholm	375	341
Alberta Hospital, Raymond	78	119
Rosehaven, Camrose	442	467
INSTITUTIONS FOR MENTAL DEFECTIVES		
Alberta School Hospital, Red Deer	940	977
Deerhome, Red Deer	1,141	1,228
EMOTIONALLY DISTURBED CHILDREN'S UNIT		
Linden House, Red Deer	25	10
Total	5,135	5,243

During the years 1962 to 1967, inclusive, admissions to active treatment mental hospitals increased from 2,382 to 3,474, a difference of 1,092 patients but there was a decrease of 460 patients in hospital by the end of 1967. During the same period, the number of patients in continued treatment and geriatric hospitals increased by 201. Thus, there was a net decrease of 259 patients in the combined mental hospital facilities of the Division.

The number of mentally retarded in institutions increased by 465 from 1962-67.

During 1967 several studies of existing facilities were made to assist in planning. Two older ward units were closed and a third was made unusable by a fire in which no injuries were sustained. A newly renovated ward building was occupied and a new ward building was completed. Contracts were let for an Occupational and Recreational Therapy Building and a Staff Residence at the Alberta Hospital, Claresholm, and a Services Building and a Ward Building at Rosehaven, Camrose. Another ward unit was renovated for the care of handicapped, retarded children at the Baker Memorial Sanatorium, Calgary. Plans were prepared for four new buildings to be put to tender in 1968.

The Mental Health Act continued to function satisfactorily although several complaints to the Ombudsman indicated the desirability of amendments to The Criminal Code of Canada which would extend the right of complaint to a review panel to patients detained by Order of the Lieutenant Governor in Council.

The Advisory Committee under The Psychiatric Nursing Training Act was active in a revision of nursing training and the program was expanded at the Alberta Hospital, Ponoka.

Review Panels

There were in all 52 complaints made by 22 men and 27 women. In a number of instances more than one complaint was made by the same individual.

In seven cases the Review Panel decided that the patients had improved to such an extent that certificates were no longer necessary. In only one case did the Review Panel find that the certificates should not have been issued.

Certificates were received on some 1,622 patients during the year, either on admission (1,312), or by change of form of admission (537), or by renewal certificates (266).

Preventive Services - Guidance Clinics

Although there was difficulty recruiting staff with higher levels of training, particularly psychiatrists, there was an increase in both the number of social workers and psychologists.

There was an increase of 138 new cases, 61 re-registered cases and a total of 10,427 interviews largely resulting from increased activity in the Lethbridge-Medicine Hat area.

The source of referrals and diagnostic categories show little variation from previous years.

The largest groups of diagnoses were:

Pre-School Age Group:

Transient Situational Reactions	21.9%	
Mental Deficiency	20.6%	←
Deferred Diagnoses	20.9%	
Chronic Brain Disorders	11.0%	

School Age Group:

Transient Situational Reactions	34.1%
Mental Deficiency	16.3%
Personality Disorders	15.2%

16 and Over Age Group:

Psychoneurotic Disorders	25.2%
Personality Disorders	14.6%
Transient Situational Disorders	14.4%

In all age groups, 1,164 new cases of mental deficiency were examined.

Active Treatment Hospitals

Alberta Hospitals, Edmonton and Ponoka

In 1967 there was a marked difference in the rate of admissions to the two active treatment hospitals. Admissions to the Alberta Hospital, Ponoka dropped markedly from 1,422 in 1966 to 1,241 in 1967, but at the Alberta Hospital, Edmonton, there was an increase of 183 admissions from 2,050 to 2,231 at Edmonton, an all time high for any hospital in the Division. Similarly, there was a higher rate of voluntary admissions, 60.4% at the Alberta Hospital, Edmonton, than at the Alberta Hospital, Ponoka, (44.62%) as well as a higher number of forensic admissions, 186 and 59 respectively.

The differences between the two hospitals are possibly due to the proximity of the Alberta Hospital, Edmonton to the City of Edmonton and also to the enlargement of the out-patient program of the Alberta Hospital, Ponoka, in the City of Calgary.

An examination of the diagnoses assigned on first admission and on readmission at both hospitals revealed the seriousness of schizophrenia. Nineteen per cent of first admissions and 33% of readmissions were assigned that diagnosis in 1967. At the end of the year, 49% of patients registered at the two hospitals were classed as schizophrenic.

Alcoholism was another prominent diagnosis, accounting for 22% of first admissions and 24% of readmissions. (NOTE: Ranking third, fourth and

fifth in frequency of diagnosis among first admissions, as shown in statistics presented in the report from the Division to the Alberta Mental Health Study, were: "pathological personality," 9%; "neurotic depressive reaction," 8%; and "psychoses with cerebral arteriosclerosis," 7%. Among readmissions, and following "schizophrenia" and "alcoholism," the next ranking categories were: "pathological personality," 7%; "manic depressive," 7%; and "neurotic depressive reaction," 5%. The first five ranking categories named above accounted for 65% of first admission diagnoses and 76% of readmission diagnoses.

"Alcoholism," with or without psychoses, however, comprises only 5% of the total diagnoses assigned to patients, who were registered at the two hospitals at the end of December 1967, presumably reflecting the relatively short stay in hospital, generally speaking, of persons with that diagnosis. Other diagnostic categories found at year's end with similar frequency were: "manic depressive," 5%; "senile psychoses," 5%; and "psychoses with cerebral arteriosclerosis," 7%. Diagnostic categories found less frequently were: "psychosis of other demonstrable etiology," "paranoia," "involutional melancholia," "mental deficiency without psychosis," "other unspecified psychoses," "pathological personality," and "neurotic depressive reaction." Schizophrenia, alcoholism and the other categories referred to in this parenthetical analysis accounted for 90% of the patients registered at the two "active treatment" mental hospitals at the end of 1967. W.R.N.B.)

Both hospitals carried out active treatment programs in keeping with current concepts and the out-patient programs of both hospitals were enlarged during 1967. Halfway houses and foster home programs were well patronized by the hospitals.

(NOTES: 1. As of December 31, 1967 there were 960 patients in hospital at Ponoka and 1141 at Edmonton. Ponoka began the year with 1029 patients, admitted 1241, excluding transfers, discharged 1280, also excluding transfers, and there were 74 deaths. Comparable figures at Edmonton were: 1253, 2233, 2149 and 88. These figures reflect a large work-load and social need.

2. Classifications by age of persons, who were admitted and readmitted to the Alberta Hospitals at Ponoka and Edmonton during 1967, were as follows: Under 15 years, 0.8% of the total; 15-20 years, 6.1%; 20-24, 10.1%; 25-29, 9.8%; 30-34, 11.1%; 35-39, 12.0%; 40-44, 12.6%; 45-49, 9.2%; 50-54, 8.2%; 55-59, 5.9%; 60-64, 4.4%; 65-69, 2.6%; 70 and over, 7.2%. The age distributions of first admissions were similar, with readmissions tending to be slightly older in general, the median age in each case falling in the middle 30's. W.R.N.B.)

Continued Treatment Hospitals

Alberta Hospital, Claresholm
Alberta Hospital, Raymond
Rosehaven, Camrose

At the Alberta Hospital, Claresholm, a new building was not completed until the end of the year, thus delaying the planned redistribution of patients at Raymond. Construction was commenced in the late fall on an Occupation and Recreational Therapy Building and a Staff Residence for both men and women. The patient population at the end of the year was 105 men and 236 women, one less than in the previous year.

There were no changes in the operation of the Alberta Hospital, Raymond. There were 117 patients in residence at the end of the year, compared with 119 on December 31, 1966.

The number of patients at Rosehaven, Camrose, was reduced by 17 due to the demolition of a small temporary ward unit in preparation for other construction. There were 91 deaths chiefly from degenerative heart disease and terminal pneumonia. The average age at death was 83.5 years. (Most of the patients at Rosehaven are transferred from the active treatment hospitals and are persons who could not be cared for in nursing homes.)

Institutions for Mental Defectives

Alberta School Hospital, Red Deer
Deerhome, Red Deer

The Alberta School Hospital, Red Deer, patient population increased by 55 to 977, including patients cared for at the Baker Memorial Sanatorium where another section was made available for wheelchair patients.

Dr. J. M. Brown was appointed Superintendent of Deerhome on July 1 providing much needed administrative leadership and co-ordination of programs. Two patient placement officers were appointed to supervise trainees in employment in the community and do follow-up work. The patient population was increased by nine to 1,228.

Unit for Emotionally Disturbed Children

Linden House, Red Deer

The general program of this facility was unchanged. Six children were admitted and eleven were discharged. There was a lesser demand for admission, but it is still considered that this unit provides a valuable treatment program for emotionally disturbed children. The rated capacity of Linden House, as of April 30, 1968, was 25. There were 13 children in residence on that date.

Related Guidance Clinic Statistics, 1967*

The workload at 5 clinics in 1967 is summarized below.

1. Calgary: 29,708 activities (5700 patient interviews, 5721 related contacts with relatives or concerned persons, 2180 psychological examinations, 16284 other contacts or services to community). Staff comprised: 3 psychiatrists, 9 psychologists and 8 social workers.
2. Edmonton: 27,304 activities (4366, 7263, 2428, 13247) with a staff of 5, 9 and 11 classified as in Calgary data and rounding off figures for part-time staff.
3. Lethbridge-Medicine Hat: 6,415 activities (2540, 2587, 648, 640); staff of 1, 3 and 3.
4. Ponoka: 969 activities (671, 167, 73, 58); staff of 4 and little part-time psychological and social work assistance.
5. Red Deer: 4052 activities (1973, 1355, 568, 156); staff of 1, 2 and 1.
6. Total activities: 68,448; 15,250 patient interviews, 17,093 related contacts, 5,897 psychological examinations.
7. Total new cases, 1929-1967: 50,167.

*Summarized from data presented in the report from the Division to the Alberta Mental Health Study.

PRESENT AND FUTURE TRENDS

The population in Alberta in 1966 is reported as 1,463,203, an increase of approximately 10% from 1961. The increase between 1956 and 1961 was approximately 19%. The population would be distributed almost evenly by an east-west line through Wetaskiwin. The two largest centres of population, Edmonton (382,933) and Calgary (330,575), with their immediately adjacent areas contain about one-half of the total population. Treatment "Centers" are required in each of four service areas to serve the numbers of people indicated: Lethbridge-Medicine Hat, 146,000; Calgary, 433,000; Red Deer-Ponoka, 200,000; and Edmonton and the North, 685,000.

Another factor determining the need for mental health services in Alberta is the change in rural and urban populations. The rural population in Alberta decreased from some 449,000 in 1946 to some 405,000 in 1966, whereas the urban population increased from 354,000 to 1,058,000. This concentration of population in urban centers, with better roads and faster means of transportation, makes it less necessary to have treatment centers in rural areas. The proposed Alberta Mental Health Centre in Calgary would be in a position to service over 400,000 people. The Centre is designed to provide a hospital with facilities for an Adult Day-Night Care Unit, an Alberta Guidance Clinic, an Out-patient Centre, treatment units for Emotionally Disturbed Children and Adolescents and required Recreational and Educational facilities.

Table 14 gives the urban, rural and total population in the Province for the census years 1941-1966.

Table 15 reports the total admissions, 1946-1966, at the Alberta Hospitals, Ponoka and Edmonton, and the rate of admissions per 1,000 of population. Table 15 shows a steady increase in admissions per 1,000 and thus a growing demand for the services of mental hospitals or alternate facilities.

Mental Retardation

The problem of the mentally retarded requires continued attention. About 3% of the total population, or 45,000 persons, are involved and most of them can benefit from training. The Province has some 193 special classes in the public schools accommodating about 2,500 students with intelligence quotients of approximately 50-80. The classes have a small enrolment to make possible the individual instruction needed.

The Alberta Association for Retarded Children, which has been active and growing in the past fifteen years, seeks to extend training for persons below the intelligence level referred to above. The Association provides such training insofar as its resources permit. Help is received from the Department of Education, and from local sources, for the construction and operation of facilities. The Association has 14 schools operating in

TABLE 14

ALBERTA POPULATION, RURAL, URBAN AND TOTAL

Year	Rural Population	Rural Decrease	Urban Population	Urban Increase	Net Increase	Total Population
1941	489,583	-	306,586	-	-	796,169
1946	448,934	40,649	354,396	47,810	7,161	803,330
1951	444,882	4,052	494,019	139,623	135,571	938,901
1956	438,887	5,995	684,229	190,210	184,215	1,123,116
1961	429,912	8,975	902,032	217,803	208,828	1,331,944
1966	405,409	24,503	1,057,794	155,762	131,259	1,463,203

TABLE 15

ADMISSIONS TO ALBERTA HOSPITALS, PONOKA AND EDMONTON AND
RATE OF ADMISSIONS PER 1,000 POPULATION

Year	Total Admissions	Provincial Population	Admission Rate Per 1,000 Pop.
1946	715	803,330	0.9
1951	936	938,901	1.0
1956	1,479	1,123,116	1.3
1961	2,336	1,331,944	1.8
1966	3,529	1,463,203	2.4

Alberta with about 110 classes, and some 905 students. The Winnifred Stewart School for Retarded Children in Edmonton is a good example of a larger school of this type. An Industrial Research and Rehabilitation Institute will be opened this year in Edmonton. A Vocational Rehabilitation and Research Institute is planned for Calgary.

The Alberta School Hospital, and Deerhome, at Red Deer provide training in an institutional setting, and continued care as required.

The figures above indicate that much remains to be done for the mentally retarded. On April 30, 1968, the Alberta School Hospital had 990 patients, Deerhome 1309, the public school classes for retarded have 2,500 pupils and some 905 were receiving training under the Association for Retarded Children, for a total of 5,704 or about 13% of the estimated number of mentally retarded in the Province. However, a considerable number of the total are adults and no longer in the age group most suitable for training. Also, a number of adult defectives, possibly 1,000, are receiving disability pensions because of their mental deficiency.

It is suggested that the mentally retarded should have some type of guardian of their person, through whom they could receive counselling and protection as required. This protection is provided for their estates now through the Public Trustee. The Child Welfare Division of the Public Welfare Department can assume guardianship by court order under certain circumstances. As adults, however, there is no established guardian to whom they can turn at any time. A guardian could act in a supervisory and directive capacity as required and modify for the better the treatment at times given adult defectives, by employers, foster parents, and on occasions their own parents.

Research

The Director of the Division of Mental Health has been provided with \$10,000.00 in the last two years (1966-67) to initiate research projects in Alberta Guidance Clinics, Alberta Hospitals, and in collaboration with the Departments of Psychology, University of Alberta, and University of Calgary.

It is planned to expand research in the mental health field in the coming years. One major problem is the collection and use of data from hospitals and clinics, and steps have been taken already to standardize the records and returns to make them more useful.

There are several research areas under active consideration, including geriatric needs, the problems of schizophrenia and alcoholism. The last two in particular need further intensive study as indicated earlier with reference to incidence.

Mental Health Research Grants

Grants approved under the Public Health Research Grant program, 1960-68, are outlined below. Final results of most of the projects are not available.

<u>Name of Project</u>	<u>Principal Investigator and Position</u>
<u>1962-63</u> Effect of Anti-Depressive Treatment on Extin- guished Conditioned Responses in Depressive Psychosis (Renewed Fiscal Year 1963-64)	Dr. R.R. MacLean, Department of Health
<u>1964-65</u> Therapy of Depressive - Objective Indicators	Dr. K.A. Yonge, Prof. and Head, University of Alberta
Follow-up Survey of Effectiveness of a Provincial Guidance Clinic	Dr. A.R. Schrag, Clinic Psychiatrist
Study of Various Treatments of Thumb and Fin- ger Sucking and Their Psychological and Dental Effects (Renewed for Fiscal years 1965-66, 1966-67, 1967-68)	Dr. R.D. Haryett, Associate Professor, University of Alberta
The Prediction of Amentia Level in Mongolism (Renewed 1965-66)	Dr. D. Gibson, Assist. Prof. University of Calgary
<u>1965-66</u> Therapy of Depression: Objective Indicators for Different Therapies	Dr. K.A. Yonge, Prof. & Director, Univ. of Alberta
Factor Analytic Studies of Tests of Human Brain Damage and Tests of Mouse Emotionality (Renewed Fiscal Year 1966-67 and 1967-68)	Dr. J.R. Royce, Prof. and Head, University of Alberta
<u>1966-67</u> Objective Indicators for the Diagnosis and Treatment of Depressive Illnesses	Dr. K.A. Yonge, Prof. and Head, University of Alberta
Memory Storage and Brain Damage	Prof. A.E.D. Schonfield, Prof. & Head, Univ. Calgary
Measurement of Anxiety and Depression within a Psychiatric Population	Dr. C.G. Costello, Assoc. Prof., Univ. of Calgary
Identification & Laboratory Diagnosis of Amino Acid Disorders that Lead to Mental Retardation in the Newborn (Renewed Fiscal Year 1967-68)	Dr. D.J. Campbell, Biochemist, University of Alberta Hospital
<u>1967-68</u> The Amnesic and Therapeutic Effects of E.C.S.	Dr. C.G. Costello, Assoc. Prof., University of Calgary
Therapeutic Implications of a Revised Differentiation of Depressive States	Dr. K.A. Yonge, Prof. and Head, University of Alberta

The Psychiatric Nurses Association Act and The Psychiatric Nursing Training Act

The provisions of these Acts provide for the establishment and control of the Psychiatric Nurses Association and of the training of psychiatric nurses. The first was passed in 1963 and amended in 1966. The first training act was passed in 1955, later repealed and replaced by the present act in 1966. The Psychiatric Nursing Training Act provides for an Advisory Committee of twelve members under the chairmanship of the Director of Mental Health, with six members constituting a quorum. This Committee performs duties and functions in respect to (a) "the training and qualification of persons to become psychiatric nurses, (b) the training and qualification of persons to become mental deficiency nurses, and (c) the qualification of persons to become psychiatric nurses, or mental deficiency nurses by the recognition of equivalent training obtained outside the Province." "A certificate in psychiatric nursing or in mental deficiency nursing shall be issued only to a person found by the committee to be qualified to receive that certificate."

A certificate of qualification in psychiatric nursing is required for membership in the Psychiatric Nurses Association, and to be entitled to use the designation "Registered Psychiatric Nurse." Other provisions as well are given in the Acts to control the practice of psychiatric nursing. Most of the restrictions are removed when nursing service is given by those who are members of the family of the mentally ill person, or by persons employed primarily in a domestic capacity, or enrolled in a training course to become a psychiatric nurse, a registered nurse, a mental deficiency nurse, or a licensed nursing aide, or by a person employed in a hospital as an orderly, or by a graduate or registered nurse.

PER DIEM COSTS IN ALBERTA HOSPITALS

Articles have been written and verbal statements made from time to time concerning costs in Alberta Hospitals and comparisons have been made with other hospitals and institutions. The following information is offered for consideration and evaluation.

The costs per patient day given below are based on figures given in the annual reports for the fiscal year 1965-66 for the institutions operated by the Department of Health. These per patient day costs have been adjusted to exclude medical and dental staff expenses to make them more comparable to the costs used for general active treatment hospitals and auxiliary hospitals, which also exclude physicians' fees and dentists' fees. Nursing home charges are given as \$7.50 per day. This is a set charge and includes some margin of profit and other expenses. The figures used for general active treatment and auxiliary hospitals are taken from the "Annual Report of the Alberta Hospitalization Benefits Plan" for 1966. The average costs used for general active treatment hospitals are for those of 500 beds and over, less average per diem costs for "Interest," "Depreciation" and "All Other," which are not included in provincial institutional charges.

Gross average per patient day charges for general hospitals of 500 beds and over for 1966 are given as \$38.70. Adjusted charges, gross average less "Interest," "Depreciation" and "All Other," are \$33.24 per day. Gross average charges per patient day for auxiliary hospitals for 1966 are \$13.46. Adjusted charges, as above, are \$11.63. The gross and adjusted charges for Alberta Hospitals are shown below. These adjusted charges are gross charges less expenses for physicians' and dentists' services.

TABLE 16

GROSS AND ADJUSTED COSTS PER PATIENT DAY FOR ALBERTA HOSPITALS, 1965-66

	A.H. Edmonton	A.H. Ponoka	A.H. Claresholm	A.H. Raymond	A.S.H. Red Deer	Deerhome Red Deer	Rosehaven Camrose
Gross Per Diem Costs	\$7.44	\$8.42	\$7.26	\$4.97	\$9.46	\$6.90	\$6.04
Adjusted Per Diem Costs	\$6.95	\$7.91	\$7.23	\$4.95	\$9.32	\$6.86	\$5.99
Average Adjusted Per Diem Costs	\$7.43 (Alberta Hospitals, Edmonton and Ponoka, only)						

It should be kept in mind that many of the expensive facilities and services of active treatment hospitals are not required in a mental hospital or are required to a much lesser degree. Among these are: operating room theatres, intensive care units, extensive laboratory and x-ray services, along with the trained personnel to staff them.

A survey was made of patients in the Alberta Hospitals at Edmonton and Ponoka to determine how many might need care about equivalent to that which would be provided by a general active treatment hospital, by an auxiliary hospital, and by a nursing home. Such a study cannot be considered accurate in all respects but it may be useful for comparative purposes. It is considered that, of all the patients in the Alberta Hospitals at Edmonton and Ponoka, some 43.3% require the type of care given in a general hospital, 24.4% the care of an auxiliary hospital, and 32.3% the care of a nursing home. Assuming 1,000 patients were all assigned to an Alberta Hospital instead of distributing them to other institutions according to the percentages above, comparable costs per day would be as shown in Table 17.

TABLE 17

COMPARATIVE TABLE OF COSTS FOR EQUIVALENT TYPE OF CARE IN
INSTITUTIONS OTHER THAN ALBERTA HOSPITALS

Equivalent Type of Care Institutions	Per Cent of Patients	Number of Patients	Per Diem Rate	Total Costs
Active Treatment Hospital	43.3	433	\$33.24	\$14,392.92
Auxiliary Hospital	24.4	244	11.63	2,837.72
Nursing Home	32.3	323	7.50	2,422.50
Totals	100.0	1,000	19.65 (av.)	\$19,653.14
Alberta Hospitals, Edmonton and Ponoka only			7.43 (av.)	7,430.00
Incréase in Costs			12.22 (av.)	12,223.14

Assuming that patients at Claresholm and Raymond require care equivalent to that given in nursing homes, and those at Rosehaven require care equivalent to that given in an auxiliary hospital, comparable costs would be as shown in Tables 18 and 19.

The information given regarding per diem rates in provincial and other institutions reflects favourably on Alberta Hospitals. Costs do not tell the complete story, of course, but they are an important consideration. Costs are increasing, associated with general cost of living increases, and also with the constant efforts made to provide more effective treatment.

TABLE 18

COSTS PER DAY FOR ALBERTA HOSPITALS, CLARESHOLM AND RAYMOND, COMPARED TO NURSING HOME CHARGES

Alberta Hospital	Number Patients	Per Diem Rate	Total Per Day	Nursing Home Rate	Nursing Home Total	Rate Difference	Total Difference
Clareholm	320	\$7.23	\$2,313.60	\$7.50	\$2,400.00	\$0.27	\$86.40
Raymond	120	\$4.95	\$ 594.00	\$7.50	\$ 900.00	\$2.55	\$306.00

TABLE 19

COSTS PER DAY FOR ROSEHAVEN, CAMROSE, COMPARED TO AUXILIARY HOSPITAL CHARGES

	Number Patients	Per Diem Rate	Total Per Day	Auxiliary Hosp. Rate	Auxiliary Hosp. Rate	Rate Difference	Total Difference
Rosehaven	500	\$5.99	\$2,995.00	\$11.63	\$5,815.00	\$5.64	\$2,820.00

MEDICAL SUPERINTENDENTS, DIRECTORS AND MEMBERS OF BOARDS

MEDICAL SUPERINTENDENTS

ALBERTA HOSPITAL, PONOKA (Provincial Mental Hospital)

- | | |
|--|---|
| 1. Dr. D. T. Dawson | 1911 to 1916 |
| 2. Dr. E. H. Cooke | 1916 to August 14, 1931 |
| 3. Dr. C. A. Baragar
Acting Superintendent | August 15, 1931 to March 15, 1932 |
| 4. Dr. Geo. A. Davidson | March 16, 1932 to December 31, 1935 |
| 5. Dr. C. A. Baragar | January 1, 1936 to March 8, 1936 |
| 6. Dr. Randall R. MacLean
Acting Superintendent | March 9, 1936 to May 31, 1948
March 9, 1936 to July 1937 |
| 7. Dr. T. C. Michie | June 1, 1948 to September 30, 1965 |
| 8. Dr. J. M. Byers | October 1, 1965 to |

ALBERTA HOSPITAL, EDMONTON (Provincial Mental Institute)

- | | |
|-----------------------------|------------------------|
| 1. Dr. D. L. Dick | 1923 to 1929 |
| 2. Dr. Chas. P. Fitzpatrick | June 1929 to July 1931 |
| 3. Dr. W. J. McAlister | July 1931 to 1947 |
| 4. Dr. A. D. MacPherson | 1947 to June 16, 1966 |
| 5. Dr. J. L. Paterson | June 1966 to |

ALBERTA SCHOOL HOSPITAL, RED DEER (Provincial Training School)

- | | |
|-------------------------|---|
| 1. Dr. W. J. McAlister | August 1922 to 1931 |
| 2. Dr. D. L. McCullough | August 10, 1931 to July 3, 1949 |
| 3. Dr. L. J. le Vann | August 1949 to December 3, 1951
October 6, 1952 to |

During the absence of Dr. le Vann December 1951 - October 1952 Mr. A. W. Fraser, a psychologist, was Acting Superintendent.

HOSPITAL FOR RETURNED SOLDIERS, RED DEER (Operated 1918 to 1923)

1. Dr. D. L. Dick, Resident Medical Officer, under the general supervision of Dr. E. H. Cooke, Superintendent of the Provincial Mental Hospital.

DIRECTORS OF MENTAL HEALTH DIVISION

1. Commissioner of Mental Institutions and Director of Mental Health.

Dr. C. A. Baragar September 1930 to March 8, 1936

2. Director of the Division of Mental Health

Dr. Randall R. MacLean	
Acting Director	March 9, 1936 to May 31, 1948
Director	June 1, 1948 to August 1965

Dr. A. R. Schrag
Assistant Director

October 1, 1964

3. Dr. T. C. Michie October 1, 1965 to July 31, 1966

Dr. A. R. Schrag
Assistant Director October 1, 1964 to September 30, 1966

4. Dr. A. R. Schrag October 1, 1966 to

Dr. F. J. Edwards
Assistant Director October 1, 1966 to

MEMBERS OF BOARDS

EUGENICS BOARD

The first Eugenics Board was appointed following the "Sexual Sterilization Act" of 1928. The original Board members were:

Dr. John M. MacEachran, Ph.D., Edmonton (Chairman)
Dr. Egerton L. Pope, Edmonton
Dr. E. G. Mason, Calgary
(Mrs.) J. W. (Jean H.) Field, Kinuso

In April, 1937 Mrs. Field resigned because of ill health and was replaced by Mrs. E. C. Pardee, Edmonton. In July 1938, Mrs. Pardee resigned and Mrs. Field was re-appointed. Dr. E. G. Mason died on January 3, 1947. His position was filled by the appointment of Dr. E. R. Selby of Calgary.

Other persons, who have served on the Board, include Dr. W. R. Fraser, Calgary (1955-64); Dr. Arthur V. Follett (1964-); Dr. R. Kenneth Thomson, Edmonton (1950-), who became Chairman in 1965; Mrs. Roderic B.

Gunn, Lloydminster (1949-56); Mrs. C. T. Armstrong, Calgary (1956-);
Mr. A. W. Fraser, Edmonton (1965-66); Mr. H. E. Panabaker, Calgary (1966-67)
Dr. W. R. N. Blair, Calgary (1967-68); Dr. David Gibson, Calgary (1968-).

As of May 1968 the Eugenics Board consisted of:

Dr. R. K. Thomson, Edmonton (Chairman)
Dr. A. V. Follett, Calgary
Dr. David Gibson, Calgary
Mrs. C. T. Armstrong, Calgary

MEMBERS OF THE BOARD OF VISITORS

The first Board of Visitors for Alberta was appointed at the request of the Minister of Health, by Order-in-Council 1496/25 in 1925. The Board members were:

Dr. J. M. MacEachran, Ph.D., Edmonton (Chairman)
(Mrs.) Emily Murphy, Magistrate, Edmonton
Mr. W. Botterill
(Mrs.) J. F. Anderson
(Mrs.) Jean H. Field

This Board was replaced by the members of the Eugenics Board acting as a Board of Visitors from 1929 to 1959. Effective January 1, 1960, a separate Board of Visitors was established consisting of:

Dr. W. W. Cross, Edmonton (Chairman)
(Mrs.) C. T. Armstrong, Calgary
Dr. H. E. Smith, Ph.D., Edmonton

On October 15, 1966 membership was changed to comprise:

(Mrs.) C. T. (Ellen) Armstrong, Calgary (Chairman)
Monsignor J. E. le Fort, Calgary
Reverend E. J. Thompson, M.A., Ph.D., Edmonton
Judge Nelles V. Buchanan, Edmonton

Mrs. Armstrong became Chairman of the Board of Visitors in May 1968.

CHAPTER 3

MEDICAL OFFICERS OF HEALTH

An attempt will be made in this Chapter to report the main themes and points of view contained in briefs submitted to the Director of the Alberta Mental Health Study in 1968. In all cases the original submissions will be shortened. Where possible, duplication within subject areas will be reduced by using one brief as the focus and others will be related to it. As an example, a shortened brief based on Dr. K. Adler's original will be recorded and others from Dr. G. H. Ball, Dr. F. J. Covill, Dr. John B. Newton, Dr. H. M. Richards and Dr. D. M. K. Williams will be cited and related to Dr. Adler's. All of these gentlemen are Medical Officers of Health and they tend to deal with similar problems and solutions in the mental health field.

Dr. K. Adler, M.O.H. Chinook Health Unit

The facilities of provincial mental health services are fragmented, at times overlapping, sometimes duplicated and rarely coordinated.

The services, with the exception of the Provincial Guidance Clinics, are institutionally and not community orientated. There is little or no communication between the psychiatrists employed at the mental institutions and general practitioners, M.O.H. or social agencies. This lack of communication and cooperation has caused some loss of confidence in the services, which probably is not completely justified. Many patients relapse and general practitioners and M.O.H. see mostly the failures and they naturally conclude that the percentage of recovered patients is not impressive.

Many times patients are discharged from mental hospitals and return to an environment that was often, at least partially, responsible for the patient's illness. The patient's family physician or M.O.H. are not notified of an impending discharge so arrangements cannot be made to prepare the family and to arrange to assist the patient to get integrated again into the community. Very often the first indication that a patient has returned from a mental hospital is a frantic call from the patient's relatives or neighbors stating that the patient is demolishing the furniture or has withdrawn and sits closed up in a cupboard and refuses to come out.

Mentally and emotionally disturbed people can put a terrible strain on a family and they can have a devastating effect on family life, especially on small children. Therefore, I believe that the relatives of mental patients should be thoroughly briefed on what to expect when a patient returns.

In contrast, the staff of the Provincial Guidance Clinics and the staff of the local Health Units work in close cooperation. The M.O.H. refers the patient, makes the necessary appointments and the psychiatrist makes the diagnosis, gives the treatment, sends a full report to the Medical Officer of Health and the public health workers provide after care and send a progress report back to the psychiatrist. The effect of the treatment can thus be evaluated.

The Division of Tuberculosis Control and the local health services work together in a cooperative way and the public health people in the rural areas do all the after care and make sure patients have the requested x-rays and check-ups. These arrangements have produced excellent results and I am sure are responsible for the enviable reputation Alberta has in the control of tuberculosis.

Private psychiatrists are very willing to use the services of public health personnel. I wonder why similar arrangements can not be made between the mental health services and public health services which are both Government agencies.

As I recall, for at least twelve years, the M.O.H. of this Province has offered his services to the Mental Health Division, but the response has not been encouraging.

It is obvious that the Division is not in a position to provide after care, at least not in rural areas. It is distressing to note that established and available local services are not used. No extra staff would be required for such services and no extra costs to the taxpayer would be involved. Health Units provide community health services and are the logical organization to provide after care services for patients discharged from mental hospitals. The M.O.H. and his staff are familiar with the community and know all the local sources that are available to assist such people. The Public Health Nurse is a respected member of the community and counselling, supervision, home visits, health education and referrals are her stock and trade. She knows the families and their problems. About 95% of all infants and pre-school children have been immunized by the Public Health Nurse and almost 100% of all school children are seen at some time by the Public Health Nurse for vision testing and measurement of weights and heights.

To provide better mental health services in rural areas travelling psychiatric clinics should be established. Guidance Clinics serve rural areas but will only see children up to the age of about 18 years. Appropriate fees for such services could be charged and therefore no

additional cost to the taxpayer would occur. The personnel of Health Units would be pleased to supply case histories and assist a travelling team in every way possible, e.g., in providing office space.

Another unsolved problem concerns geriatric patients who have become somewhat senile or confused, forgetful, depressed and occasionally quarrelsome. Nursing homes and chronic hospitals do not like to admit such patients. Since these old people are not really insane, no one likes to certify them and, in any case, certification is most upsetting, not only to the patient but also to the relatives. Special homes or lodges, or annexes to established hospitals should be made available for such patients.

An effort should be made to admit emotionally disturbed patients to municipal hospitals. In rural areas some hospitals do admit such patients but others are very reluctant to do so. A province-wide policy concerning such admissions should be inaugurated.

Mental health services can be divided into three main categories:

1. Prevention
2. Diagnosis and treatment
3. After care

Prevention is obviously the most rewarding and economical way to tackle the problem. This requires planning and cooperation of all available resources, e.g., general practitioner, public health workers, social workers, teachers, clergy and organizations interested in mental health. More and more children are found to be in need of psychiatric treatment. If they could be found and treated promptly many major breakdowns later in life would be prevented.

Diagnosis and treatment are the domain of the psychiatrist. However, once the diagnosis has been established and the patient has received adequate treatment and is well enough to return to his community, either the patient's doctor or the local M.O.H. should be notified so that arrangements can be made to help the patient adjust to community life.

After care can be carried out readily by public health personnel, in cooperation with the patient's doctor. It is distressing to see so many recovered patients return to their homes only to break down again due to lack of after care. On several occasions, at the special request of patients and their families, my staff and I have carried out supervision and supportive treatment of discharged patients and not one of them required readmission. This was only possible because we had exemplary coöperation from the psychiatrist, private physician, social workers, family bureau and local organizations.

The present curriculum for health education in our schools is not up to date and certainly is not realistic. Students are taught about R.H.

incompatibility, details of antibody antigen reactions and other rather complicated medical facts which are of little use to them and much too advanced. Courses in health education should be determined and supervised by a committee of educators and medical doctors, with emphasis placed on practical, down-to-earth matters. The following subjects should be taught:

1. Basic principles of modern psychology.
2. Sex education (psychology of reproduction and the psychology and moral aspects of same).
3. Venereal disease.
4. Family planning.
5. Alcohol and drug abuse.
6. Emotional and behavior patterns.

A crying need exists for proper educational facilities for children of low I.Q. The severely retarded need special schools and institutions. Such institutions do exist but unfortunately are overcrowded and often it takes years to get children admitted. However, many could be educated and trained in their own communities if special classes, like opportunity classes, were available. Unfortunately, such classes rarely exist in rural areas. For instance, the Chinook Health Unit with a school population of 5,919 has only one opportunity class and at least five more are badly needed.

Dr. John B. Newton, M.O.H.
Leduc-Strathcona Health Unit

Dr. Newton also pointed to "the problem of communication" between mental hospitals, health units, physicians and other agencies as being "a continuing source of frustration and annoyance" resulting in "much ineffectual and time consuming effort." He repeated Dr. Adler's claim that health units in his words had "consistently expressed willingness to assist and have often been involved with families where there is mental illness in the home, but without benefit of effective liaison," particularly "between the Mental Health Division and ourselves."

On the subject of restraints imposed because of confidentiality of mental illness information he noted "doctors are not necessarily selected by the public as first choice for confidential matters, the public is used to going to social workers and agencies of many sorts with their problems," and "confidentiality is an inadequate alibi for poor liaison and inaction."

He also questions, on the ground of difficulties for a family, the necessity for certification by two medical doctors, arguing that the protection of a patient "lies in correct procedure at the mental hospital."

His main point was that all resources must be mobilized to deal with poor mental health and that there are "doctors and nurses and social workers and others willing and eager and competent to help with the minimum of guidance and direction" if effective liaison existed.

Dr. G. H. Ball, M.O.H.
City of Edmonton

Dr. Ball is the author of the Report of the Special Legislative and Lay Committee Inquiring into Preventive Health Services in the Province of Alberta (the Ball Commission, 1966) and a veteran of 30 years service in public health administration, including twenty-five in local health services in Alberta. In his submission to the Alberta Mental Health Study, 1968, he made the following points:

1. With the exception of child guidance clinics, mental health services under governmental direction in Alberta have an institutionalized viewpoint. Local health services have formally and informally, for over 15 years, urged cooperation in opening up field services.
2. Staffing and financial strictures have been partly to blame but other factors have had a strong negative influence including: poor communication, professional "in-fighting," lack of vision in developing field organization.
3. Field services could be improved by integration and organization on a zone basis throughout the Province.
4. Local health units offer a basis for the achievement of the objective, stated in #3, in being, providing universal coverage, concerned with the total health of communities and accepted by the people. "No agency other than Public Health has an established, ongoing and welcome entrance into the homes, businesses, etc. of the community," and "The public health nurse has rapport with the family unit as an advisor on health dating back fifty years or more in Alberta."

As an example of the universal coverage attributed to health units by Dr. Ball he stated that over 90% of the infant and pre-school group attend local health service clinics for guidance. In addition, he noted that almost all school children are under the health supervision of the public health nurse and M.O.H.

Dr. Ball made it clear that he was not claiming mental health as a responsibility of the health units alone. He viewed the units as a "focal point from which coordination of effort" of all persons and agencies concerned with field services in mental health could take place. He noted that no other base for the establishment of field services was apparent and that alternatives, with health units in existence, would be wasteful.

One observation made by Dr. Ball may be regarded an important limitation. He proposed that existing health units "should provide the necessary organization and carriage of services from the Mental Health Division to the field - operating as an extension to the arm of that Division."¹

Dr. F. J. Covill, M.O.H.
Minburn-Vermilion Health Unit

Dr. Covill recommended that guidance clinics and health units collaborate in the provision of mental health services for rural Alberta. He saw general hospitals as the proper agency to treat most cases of mental illness with mental hospitals reserved for "particular problems or techniques."

He also noted that mental illness is not simply the responsibility of the Department of Health. "The Departments of Welfare and Education must become involved."

Dr. H. M. Richards, M.O.H.
Peace River Health Unit

A program, which coordinates the community services, institutions, and people concerned with mental health and subnormal individuals, should be launched immediately. This would: (1) relieve the present acute situation with regard to institutional accommodation caused by the number of new admissions and readmissions; (2) increase the efficiency and economy of patient care; (3) increase community satisfaction in this area; (4) improve the attitude of the public to mental health and subnormality.

In approaching a total community program for the care of the mentally handicapped, it is submitted that all groups involved in the projected program should have easy access and frequent consultation during the planning stages. Two main groups should be drawn up: one associated with professional medical care (e.g., institutional, etc., representative of the medical and nursing professions) and the other associated with the planning of a program (voluntary organizations, fund raising bodies, university, welfare, etc.). These two groups should cooperate in close liaison.

¹ I supported the idea of making much greater use of health units in Volume I, particularly in the after care of released patients. I did not see them as only an adjunct or an extension to the old Division of Mental Health, however. Instead, I proposed the integration of health and welfare units, alcoholism clinics and guidance clinics under one administrative head, preferably in the same building and I concluded that "the M.O.H. is the logical, central figure" in that context. I also noted that a model arrangement appeared to be emerging in Edmonton. (Volume I, p. 182). Dr. Ball was the originator of the "arrangement" and it is now an active and impressive development. W.R.N.B.

Liaison must exist between medical services in institutions and public health services in the community. Professionals dealing with mental handicaps should come to regard mental ill health as they do physical ill health. In this area the barrier between various medical factions and disciplines must be broken down before we can tackle the problem of institutional-community barriers.

The line of communication of personal, confidential, medical information would be from the institution to the individual's physician or to the Medical Officer of Health.

Dr. D. M. K. Williams, M.O.H.
Big Country Health Unit

Dr. Williams contended that health units are strategically located and able to provide "follow-up and support" for persons released from mental hospitals.

He also recorded his support of day care facilities for the children of working mothers, provincial subsidies for the training of all mentally retarded children regardless of the "sparseness" of population in rural areas.

COMMENT

The major theme of all reports from M.O.H. was that health units can be a significant contributor to mental health services. They do not have to be created or financed as new ventures. Their services are available throughout the Province right now.

In 1969 Dr. G. H. Ball, whose brief is summarized above, formed a section of Community Psychiatry within the Local Board of Health in Edmonton. The section's role is the provision of consultative services rather than direct treatment. By the fall of 1972 it was manned by two psychiatrists, two clinical psychologists, and two graduate students, one in nursing, the other in educational psychology. They provide consultation on mental health subjects and problems to professional workers and agencies, including the school systems. The need for that kind of service has been amply demonstrated by the response and growing demand. W.R.N.B.

CHAPTER 4

FAMILY PHYSICIANS

In Volume I of Mental Health in Alberta family physicians were singled out as a "strong and essential resource" in the provision of mental health services. (p. 142). In the paragraphs, which follow, a shortened version of a brief presented to the Alberta Mental Health Study, 1968, by Dr. E. R. Haynes, Assistant Professor of Community Medicine at the University of Alberta, will be recorded. In addition, comments from Dr. David Lander of Black Diamond will be reported.

Dr. E. R. Haynes

The sum total of the contribution towards mental health to be made by a family physician is a composite of his ability, his attitude and his activity. His total effectiveness will be closely related to his education and to the assistance he receives both from consultants and allied health personnel.

Is there a need in society for the services of the family physician into the foreseeable future? The Royal Commission on Health Services (1964) stated, "It is generally agreed that even with all the advantages of modern specialism, both in the fields of diagnosis and curative medicine, 50% of those licensed to practise would be needed in the field of family, general, or what might be more aptly called "personal practice."

If we accept that the family physician has a continuing role to play in society, what sort of man should he be? Some of his attributes were described by the 1951 Conference on Psychiatry and Medical Education.

"The physician has been enlightened early in his education with working concepts of the total human being, which is more than its component parts.

"He is aware of his obligations to the entire family as well as to an individual patient.

"He looks at his patient and his group of patients in the frame of their total environment, the community.

"He is aware of his own limitations and understands and makes use of the functions of other agencies and ancillary personnel.

"He recognizes his responsibility as a citizen to participate in the civic affairs of the community."

It is acknowledged that there is a significant demand and need for physicians with the time and experience necessary to handle patients at the primary care level with regard to both the prevention and treatment of mental illness. This demand is likely to continue and to increase. It

is not reasonable to suggest that fully trained psychiatrists should attempt to meet this demand.

Let us examine how physicians should acquire the understanding and skills required in the field of mental illness and how these skills can be applied.

The admission requirements of students to medical schools should be analyzed. The McFarlane Report (1967) recommended:

"Medical schools should begin to enquire more closely into the recommended pre-professional education of candidates who expect to enter medical school and to recommend such courses as are available and relevant in the social sciences. The possibility of establishing in faculties of Arts and Science special combined honour courses in the social sciences and the natural sciences should be explored."

If one-half of graduating students will become "personal physicians," greater emphasis should be placed on the admission to medical schools of those students demonstrating interest and ability in the social and behavioral sciences.

Of particular interest to the Alberta Mental Health Study is a report published in the C.M.A.J. (1964) by Dr. J. A. L. Gilbert regarding the opinion of medical graduates of the University of Alberta.

"The recommendation made most frequently, and this was made 132 times (i.e. by 27% of those replying) was that additional time should be devoted to specific general practice training. It was recommended that a program of undergraduate instruction in home and office practice, minor procedures, diagnosis and treatment of minor ailments and common diseases should be given, and that a family study program should be introduced. A high proportion of those suggesting this revision indicated that this training should be conducted by general practitioners. This proposal for general practice training was submitted just as frequently by recent graduates as by earlier ones."

Specifically with regard to psychiatry this report stated:

"The subject fourth in frequency of comment was the undergraduate program in psychiatry, which brought forth 50 comments (15% of those replying). Forty-one requested more or differently orientated training in psychiatry. Most often referred to was 'office psychiatry,' the minor psychoneuroses, the psychosomatic aspects of disease, functional disorders, and so on."

At the undergraduate level all students should receive a broad education in family dynamics, mental health and mental illness. Understanding of the problem is of greater importance than the acquisition of skills. The problems with regard to mental health are best demonstrated on ambulatory patients. Experience, therefore, should be provided for undergraduate medical students in family practice units which are community-based. Such experience should be given to all medical students whatever their ultimate destiny. The accent in such programs should be on the patient and on his family rather than on specific disease.

R. T. Martin in Undergraduate and Postgraduate Teaching in Psychiatry, 1965 states:

"The teaching of psychodynamics at the undergraduate level is one of the most neglected aspects of medical education. I take it to be important not simply because of its value to those who will eventually proceed to specialisation in psychiatry, nor because of its contribution to the student's progress in his psychiatric term. I take it to be important because I believe that an adequate appreciation of, and competence in the handling of psychodynamics, is an essential requirement for the general medical practitioner. The massive task of dealing with the problem of mental illness is beyond the capacity of the specialist psychiatrist and must be dealt with in preventive and prophylactic terms by the general practitioner."

L. G. Kiloh, in the same publication, states:

"Coming now to the problem of what to teach and how it should be taught; it is sometimes overlooked that about 50 per cent of our graduates are destined to become general practitioners. It is not only undesirable but impossible to train an undergraduate to become a psychiatrist, (so) psychiatric education (of undergraduates) should be in accord with the needs of general practice."

At the graduate level there should be training designed to equip doctors for the practice of family medicine. The Royal Commission on Health Services (1964) states:

"There is an increasing demand for a personal physician with greater training than that of the family doctor, and a tendency to employ specialists trained in medicine, general surgery, paediatrics, or obstetrics and gynaecology. Yet such specialists lack the broad training required to provide the best care to the whole family. Two years of resident training in medicine, obstetrics, paediatrics and psychiatry would produce a doctor capable of dealing with the diagnostic and therapeutic problems which do not require highly specialized diagnostic procedures or surgical treatment. As a personal physician with special training he could offer better

service to a family than can the man more highly trained in the narrow specialty, who would accordingly tend to confine his work to a consulting practice."

If family physicians of the future are to meet the needs of society adequately, they should receive graduate training not solely on hospitalized patients hospitalized for episodic illness. An attempt to provide such training in a hospital would be similar to attempting to teach forestry in the lumber yard. Graduate training programs for the practice of family medicine must be community-based and not hospital-based. Graduate students satisfactorily completing such programs should receive a certificate of competence in family medicine.

The Royal Commission on Health Services (1964) recommends that:

"In the interest of the training of the graduate for family practice the regulations governing the pre-registration internship be modified so as to permit greater flexibility," and "the College of General Practice, in consultation with the Association of Canadian Medical Colleges and the Royal College of Physicians and Surgeons of Canada, consider the development of a program of training and suitable examinations for specialist personal physicians."

The manual on "Training in Family Medicine" (1967) published by the College of Family Physicians of Canada, states (abbreviated):

"An understanding of psychiatry is indispensable to the family physician. A high percentage of the illnesses that confront a family doctor are, in whole or in part, complicated by emotional disturbances. Because of his broad responsibilities in this area, particularly for continuing care, the family physician should maintain a close liaison with the psychiatrist.

"The resident in family medicine should obtain an understanding of emotional illness in a number of settings: a psychiatric teaching unit; a hospital; and out-patient or home care settings. He should be encouraged to seek a deeper understanding of the dynamics of the family unit of which he is a part. He must recognize those patterns of behaviour that contribute to emotional stability, and encourage their development in his patients. Throughout the residency training program there must be a close liaison between the Department of Family Medicine and the Department of Psychiatry. The resident must have continuous access to psychiatric consultation and the free exchange of information. Family physicians must learn the rational use of psychotherapeutic medications. He should come to appreciate that these are not curative and should only be used as adjunctive therapy. His chief therapy has always been, and will continue to be his knowledge of the patient and his family and the confidence that this inspires. His chief instrument of therapy is

his own personality.

"The increasing importance of alcoholism and other addictions in present society, and the devastating effect of these on the family structure make it imperative that the family physician have further knowledge of the predisposing factors and modern management of these conditions."

Adequate training for the practice of family medicine has almost been totally absent in the past and must be encouraged in the future. Such training programs ideally should be promoted and supervised by our medical schools, be community based and community orientated, and encourage a much deeper understanding of the patient if the family physician is to make an adequate contribution to mental health as well as to total health care.

The Royal Commission of Health Services (1964) has expressed itself on continuing education as follows:

"The group feels very strongly that the medical schools which now have programs of postgraduate medical education should be encouraged to expand them, and that all the other medical schools should be encouraged to establish divisions of postgraduate medical education as early as possible." and

"In general, we believe financing should be on a three-way basis. The doctor who enrolls in the course provided should pay half the cost. The remaining half should be shared by the federal and provincial governments. We think that if medical care insurance is introduced this is a reasonable charge against the insurance funds." and

"The cost of attending university sponsored continuing education activities should be regarded as deductible expense for income tax purposes." and

"Part-time clinical teachers in medical schools should be allowed to deduct for income tax purposes the cost of attending four medical meetings per year."

In Alberta continuing medical education would require a program aimed at practising physicians from many angles. It would require the use of radio and probably of television as well as organizing attractively structured seminars and conferences. Leadership could be arranged through societies such as the Alberta Medical Association, the College of Family Physicians (Alberta Chapter), the Edmonton Academy of Medicine and the Calgary Medical Society, etc.

Once increased understanding and skills have been acquired by the family physician it is important that these skills should be used effectively and economically in practice. It is important that psychiatrists be available to offer help and guidance to the family physician. It is by no means necessary that all cases with psychiatric overtones be referred to the psychiatrist. Many family physicians are happy to treat their patients on a long term basis if they get occasional reassurance and guidance from a consultant psychiatrist.

The Royal Commission on Health Services (1964) recognized this when it stated:

"Psychiatry. The development of personal physicians would reduce the load on the specialist-psychiatrist and permit him to confine his activities to consultant practice."

A valuable insight into the interaction involved in such a situation is provided by Dr. R. A. Forrester in the Canadian Psychiatric Association Journal of December, 1966 in his article "The Patient, his Doctor and the Psychiatrist."

It should be seriously questioned as to whether or not the present consultant psychiatrist is not over-trained in terms of what he hopes to achieve in society. The value, for instance, of the consultant psychiatrist receiving training in obstetrics, in gynecology and in surgery should be carefully assessed.

It has been stated that a large burden has been laid upon family physicians by the policy of retaining the mentally disturbed patient in the community. Family physicians may wonder on occasions whether the enthusiastic progenitors of the concept have ever realized precisely what it means for the family physician. Collaboration of the family doctor with social agencies has become as important as his previous close contact with hospital services.

Many family physicians are not aware of the tremendous help that can be rendered to their patients by nurses, by social workers, by marriage counsellors, by psychologists and by public health nurses. At the present time in Alberta many of these services are available but cost the patient money, while the services of the doctor are covered by pre-paid medical insurance. Patients are, therefore, often reluctant to be referred to other agencies. In addition, there is a shortage of personnel in some of this fields, and a lack of integration in the provision of their services. The key words in the future in this area should be "communication," "coordination" and "cooperation."

In achieving these objectives it is recognized that communication must be established during the educational process. The Royal Commission on Health Services states:

"As many as possible of the members of the para-medical and related professions should be educated and trained in conjunction with other members of the health teams. A grouping of teaching and exemplary service in the health sciences center would facilitate such an objective."

To receive the most value from those services a central body should be formed to integrate and coordinate their activities. Such a body should be community based and, ideally, should be the focal point for all community services. (See p. 181, Volume 1 for a similar idea. W.R.N.B.)

There are approximately 1,700 active physicians registered in Alberta. Approximately 1,000 are non-specialists and are, therefore, broadly categorized as general practitioners, the majority of whom render primary care to the community and frequently encounter mental health problems. In addition, some specialties, such as internal medicine and paediatrics, render primary and/or continuing care to their patients and encounter similar problems.

The Royal Commission on Health Services has recommended that Canadian medical schools should increase the annual graduation of physicians to approximately 900, and in the succeeding four years (now) to an average of 963. The present physician/population ratio can be maintained until 1971, assuming a continued immigration of doctors into Canada of 400 each year together with the increased annual graduation mentioned above.

In the period 1955-65 there was an increase of 94% in specialists in Canada, while there was only an increase of 4.1% in family physicians in Canada. Certain specialties, such as psychiatry, are understaffed. Similarly, other specialties, such as general surgery and obstetrics and gynecology may be unduly competitive. The day cannot be far distant when either the medical profession or the government representing society will only agree to subsidize the expensive training of consultants if a future need for their services can be demonstrated.

The percentage of graduating medical students in Alberta who choose to become family physicians will be directly related to the adequacy of training provided for them to fulfil this increasingly difficult and challenging role. The development of community based and community orientated family practice units is an urgent necessity if family practice is to service and be able to provide the community services demanded in the future. Large sums of money have been devoted to the development of facilities in such areas as cardio-vascular surgery and research. Such funds have served and continue to serve a useful purpose. It is submitted, however, that it is time that the demands and needs of society with regard to the allocation of similar monies to the development of total health services, including mental health, be recognized.

In summary:

1. Family physicians occupy a key position in the prevention and in the treatment of mental illness. It is apparent that they will continue to play an important role in Canadian medicine into the foreseeable future.
2. At present family physicians are not being adequately trained and educated to assume their role, in particular with regard to prevention and treatment of mental illness.
3. Selection standards for medical schools should recognize that many graduates are destined to become family physicians; therefore, interest and ability in the social and behavioral sciences should receive increasing recognition.
4. The training of undergraduate medical students must not be limited to referred hospitalized patients. They must be exposed to ambulatory patients and to continuing and comprehensive care. They must be prepared to deal with the high psychosomatic content of the complaints of ambulatory patients. This experience should be integrated with the education of health science students in related disciplines.
5. Graduate training programs should be developed specifically for the practice of family medicine. Such programs should be community based and have a high psychiatric orientation.
6. Medical schools should be encouraged to develop programs specifically designed to increase the interest and develop the skills of physicians already in practice with regard to mental health. Such programs should involve allied health personnel and should receive adequate funding.
7. Consultant psychiatric services need to be developed which would support, guide and advise family physicians with regard to the treatment of mental illness. Such services should provide for rapid consultation in cases of unusual concern on a demand basis.
8. In the prevention and treatment of mental illness all the components of the "medical team" should be developed, integrated and used in the most effective way possible. Organizational procedures should be sought and developed to ensure "communication," "coordination" and "cooperation."

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Dr. David Lander
Black Diamond, Alberta

Family doctors should be encouraged and given the opportunity to keep up to date and to fill gaps in their training. Training non-psychiatric physicians to handle emotional problems will help them to practise more comprehensive medicine. They should be able to treat most of the organic psychoses, senile and arteriosclerotic, psychosomatic conditions, many of the neuroses, the intoxications (alcoholic and barbiturate). They should not try to treat schizophrenia but should be able to spot early cases for referral. Manic depressive psychosis, suicidal tendencies, and severe depressions are best cared for by the psychiatrist, as are psychopaths, paranoiacs, and obsessive compulsives.

A method should be formulated whereby psychiatric knowledge could be continuously available to other branches of medicine. Out-patient departments of psychiatry should be located in every large general hospital. In order to do this there must be cooperation between the various medical and mental health organizations. Post-graduate education in psychiatry should be increased, e.g., courses could be arranged through the departments of psychiatry, internal medicine and preventative medicine.

Psychiatric units in general hospitals should be administratively separate departments with equivalent status to the departments of surgery and medicine. They should have an out-patient department, in-patient treatment, consultative services and a 24-hour emergency service for the community.

Day and night care hospital wards should be established. If new mental hospitals are built, they should be in close proximity to medical centers.

Travelling teams should be established for rural areas, for consultation and referral. These teams could use the local health unit facilities and could charge a fee for their services.

It is suggested that authorities of the Alberta Hospitals should institute a program of notifying a patient's psychiatrist or family doctor when the patient is discharged. If he doesn't have a doctor, the patient should be followed up by some agency, e.g., out-patient clinic or family bureau.

Liaison officers should be established between the Alberta Hospitals and Canada Manpower so that employment and retraining possibilities could be discussed with patients.

Sheltered workshops, half-way houses, foster homes, etc., should be established. Out-patient services, including special classes, should be established for emotionally disturbed children. There is also a need for

guidance clinics for the aged and for a Minister of Aging. Provisions should be made for non-psychiatric personnel to increase their psychiatric knowledge, e.g., police, clergy, etc.

Mental health in the area of retardation should be provided as part of a broad community plan.

Family doctors should be encouraged to treat alcoholics in general hospitals. More research and public education should be carried out in this area.

Car accidents should be studied to discover how to keep unsafe and disturbed drivers off the public roads.

Industrial health programs could also profit from psychiatric orientation especially in the study of accident prevention and absenteeism.

The Role of General Practice¹

Introduction

The concept of the team approach in medicine applies particularly to mental health. It is becoming more obvious that it is impossible to train sufficient psychiatrists to care for all the people categorized as suffering from mental ill health. At present the majority of mental health problems are managed by the general practitioner. This situation will likely continue and increase as the tendency to shift the orientation of the general practitioner to the family and the community becomes more prevalent.

The medical profession must always play an important role and perhaps the leading role in the team approach to mental illness because of the legal and ethical aspects of prescribing medication and the responsibility for diagnoses and care of patients within a hospital.

Recommendations

The role of the family physician in mental health has not been clearly defined, and so it has been assumed that the psychiatrist would be the medical person to attend to all mental illness. However, in fact, the family physician does care for a large number of persons suffering from mental ill health and is assuming more responsibility out of necessity. Accordingly, the following recommendations are submitted:

1. Facilities and Service

- a. Much more emphasis should be placed on the use of active-treatment hospitals for the care of psychiatric problems. The family physician should have free access to psychiatric consultation for his patients, bed space and the other services necessary to make psychiatric care worthwhile, occupational therapy, recreational therapy and group therapy.
- b. Continuous communication between psychiatry and the other branches of medicine is extremely important. Cutting off psychiatry physically from the remainder of the active-treatment beds, either within a building or by a separate building, would widen the existing gap between psychiatry and the remainder of medicine.

¹ This is a shortened version of a paper prepared by Dr. Saunders as a member of the Study Group on Roles of Professional Personnel for the Alberta Mental Health Study, 1968. W.R.N.B.

- c. To facilitate the development of cooperating units in a general hospital, part-time psychiatric appointments could be considered.
- d. The training of psychiatrists should be changed to emphasize their role as consultants who would exert their influence on continuing care through the physicians who consult them.

2. Undergraduate Education

- a. Pre-medical education should lay more stress on the behavioral sciences as prerequisites for entering medical school.
- b. Selection committees for the medical school should become aware of the need to admit students oriented to the behavioral sciences rather than to the physical sciences.

3. Medical Education

- a. Medical students should come in contact with patients early in their training so they can build on their pre-medical years' experience in the behavioral sciences.
- b. More emphasis should be placed on community medicine, as well as psychiatry, including training in team work with allied health professions and creation of an awareness of community facilities.

4. Post-Graduate and Continuing Education

- a. The psychiatrist must be trained to be a consultant rather than a specialist; that is, the bulk of his work must be in consultation with the family physician or the allied health professions rather than direct care of individual patients.
- b. The family physician must work and consult closely with psychiatrists to maintain his interest and his necessary relationship with this branch of medicine.
- c. The government service should become involved in continuing education. The best form would be traveling teams using cases known to the local family physician and the psychiatrist as a means of teaching and outlining management roles of such other specialists as nurses, social workers, psychologists, etc.

CHAPTER 5

NURSES

ALBERTA ASSOCIATION OF REGISTERED NURSES

Preface

The Royal Commission on Health Services (1964) states:

"As we examined the hundreds of briefs with their thousands of recommendations we were impressed with the fact that the field of health services illustrates, perhaps better than any other, the paradox of our age, which is, of course, the enormous gap between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of men, on the other."

What the Commission recommends is that in Canada this gap be closed, that as a nation we now take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind. All our recommendations are directed toward this objective.

There can be no greater challenge to a free society of free men.

The Commission recommends that the following charter be accepted as an objective of national policy for Canada.

Health Charter for Canadians

The achievement of the highest possible health standards must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive,¹ universal² health services program³ for the Canadian people,

- implemented in accordance with Canada's evolving constitutional arrangements⁴;
- based upon freedom of choice⁵, and free, self-governing professions and institutions⁶;
- financed through prepayment⁷;
- accomplished through the full cooperation⁸ of the public, the health professions, voluntary agencies, all political parties, and governments, federal, provincial and municipal;
- directed toward the most effective use of the nation's health resources to attain the highest possible levels of physical and mental well-being.

1. "Comprehensive" includes those health services, preventive, diagnostic, curative and rehabilitative, which modern medical and other sciences can provide.

2. "Universal" means that adequate health services shall be available to all Canadians wherever they reside and whatever their financial resources may be, within the limitations imposed by geographic factors.

3. A "Health Services Program" would organize comprehensive, universal health care, including prepayment for health services.

4. Canada's "evolving constitutional arrangements" take into account the jurisdiction of provincial governments on health matters and the necessity for federal financial assistance.

5. "Freedom of choice" relates to the rights of patients and practitioners.

6. "Free and self-governing professions" concerns choice of location, type of practice, and self-government. With respect to "institutions" this phrase means academic freedom for professional schools and, for hospitals, freedom from political control or domination.

7. "Prepayment" means financing from premiums, taxes, supplemental from provincial general revenues and from federal grants.

8. "Full cooperation" means

(a) the responsibility of the individual to observe good health practices and to use available health services prudently;

(b) the responsibility of the individual to allocate a reasonable share of his income (by way of taxes or premiums or both) for health purposes;

(c) the methods and rates of remuneration of health personnel, (fee-for-service, salary or other arrangements) should be agreed upon by professional associations and administrative agencies, not by arbitrary decision, with an appeal procedure in the event of inability to agree;

(d) the maintenance of a close relationship between the providers and recipients of health services, safeguarding confidentiality;

(e) the provision of educational facilities of high quality and the removal of barriers to the pursuit of health service careers by suitable persons;

(f) adequate support of health research and its applications;

(g) the maintenance of indispensable voluntary agencies in the health care field;

(h) improvement of health services, supplemented by other measures concerned with housing, nutrition, smoking, water and air pollution, accidents, alcoholism and drug addiction;

(i) the development of representative health planning agencies at all levels of government, federal, provincial, regional and municipal, and integration of health planning.¹

¹ Sub-paragraphs 1-8, above, were condensed from Hall, Judge E., Royal Commission on Health Services, Ottawa, Queen's Printer, 1964, p. 10-12.

Conceptual Model

A plan for mental health services in Alberta must encompass the full scope of mental hygiene for the total population.

A zonal concept, advanced by Blain (1962), would meet that requirement

Zone I. The Prenatal and New Born Population

This includes all babies up to and including birth, with their genetic inheritance, their fetal development, and their reactions to the act of birth. Most babies who are live-born are healthy; a few are already impaired.

Zone II. The Normal Population

This Zone includes people who function normally as infants, children, adolescents, adults, middle-aged, and aged. They influence and are influenced by their nutrition, climate, families, schools, churches, jobs and various social institutions. For the most part, they handle the vicissitudes of life without formal, outside assistance.

Zone III. Troubled Population (not mentally ill)

These people are in special need and turn to "trouble-shooting" or "caretaking" resources. They seek help from doctors, hospitals, and health departments, from social agencies, welfare departments, and public assistance bureaus; from organizations for crippled children, orphans and transients; from police, probation departments, and the courts. They are under stress but they are not essentially psychiatric problems.

Zone IV. The Mentally Ill Population

This Zone includes all those with mental illness and defects of such serious degree that they cannot be cared for by the agencies servicing Zone II and Zone III populations. They need clinical psychiatric services, consultation, diagnosis, referral, and treatment.

The majority of the population are in Zone II. If all goes well, they remain there. If not, they may move to either Zone III or Zone IV. Nursing has a responsibility for helping the institutions which shape the development of "normal" people so that they can be kept mentally healthy.

The area of highest risk includes the people who face trouble, physical, social, legal or environmental, and who require assistance to deal with their troubled situation (Zone III). These are the people who come to the "caretaking" agencies. Nurses should be involved to assist Zone III people handle their stressful situations.

Another segment of the population of serious concern to nurses comprises the unborn and newborn (Zone I), some of whom are born defective and become members of either Zone III or Zone IV. To some extent this can now be prevented. The factors involved include the health of the parents, good prenatal and obstetrical care, and understanding the psychological and physical aspects of pregnancy and child rearing.

Nurses are greatly concerned with the people in Zone IV, those with psychiatric disorders: (1) the newborns from Zone I whose birth, genetic inheritance, fetal development or reaction to the event of birth has developed in them sufficient symptoms to warrant a diagnosis of psychiatric disorder; (2) those from Zone II who have developed symptoms of mental illness; and (3) those from Zone III who require psychiatric services for corollary emotional problems.

People, their needs, and the methods whereby nursing can assist with meeting these needs are identified throughout this brief in terms of the zonal concept.

Zone I

The care concept which led to the establishment of prenatal health services in the early part of the twentieth century is believed largely responsible for the good state of health enjoyed by women and children in North America (Lytle, 1967). Caplan (1959) contends we should be able, through our knowledge of a woman's reactions during pregnancy, to intervene and prevent the development of a disordered mother-child relationship. He believes we can help to give each individual a healthy start in life during the first three months before reciprocal interaction of mother and child becomes more significant.

About one out of each 200 babies is born with an abnormality serious enough to cause death; two out of each 200 births have serious physical and/or mental abnormalities which are apparent at birth. Other defects are not discovered until the child is older. Eastman (1966) estimates that three newborn infants out of every 100 are seriously impaired physically or mentally. Individuals born with congenital anomalies are classed in Zone III and some babies are born with psychiatric disorders (Zone IV). Examples of newborns in Zone III are infants with congenital anomalies, Rh factor disturbances and prematurity; in Zone IV are infants with emotional disorders and retardation. With appropriate treatment, the movement of some infants from Zone III to Zone IV can be prevented.

Discussion of Zone I Problems

Psychology of Pregnancy and Parenthood

Caplan (1959) defines stress as a situation in which one has an important problem which cannot be solved by using one's old habits of problem solving so a new way of functioning must be evolved. In order to

alter one's way of functioning he submits one must use inner resources, but there is also a need for external support.

During pregnancy the susceptibility of the individual to stress seems to be greater than usual. The woman is preparing for role changes, for example, from wife to mother with her first child. Failure to assume the new role can lead to a rejection of the fetus or later rejection of the baby (Caplan, 1959). Poor maternal-child relations can result in pathology of the infant at a very early phase (Pangalila-Ralantangie, 1965). Manifestations may be failure to thrive, sucking disorders, regurgitation and withdrawal of the child's responses to sensory stimulation, and may even produce a false picture of mental retardation (Ribble, 1965).

Preparation of parents to welcome and give emotional support to the newborn needs to be carried on before the child is born. The way the mother speaks of the fetus and her concept of the baby after birth give a good indication of the mother-infant relationship that is likely to develop (Caplan, 1960). When there are indications of abnormal pathology, intervention can be instituted prenatally.

Contacts with expectant mothers by nurses in prenatal clinics, by obstetricians, by public health nurses in the community could provide opportunities to influence parents' attitudes and to bring to light difficulties that need attention. Education is an important approach in bringing help to parents, yet prenatal classes are attended by only a small percentage of pregnant women. The family life education in the schools can play an important part in preparation for marriage and for parenthood.

Nutrition

Brandt (1963) reports that infants born to mothers with a good prenatal nutritional status are generally in either good or excellent condition at birth and the reverse situation applies. There is a higher morbidity in the subjects with poor nutritional backgrounds during the first year of life. Effective nutritional protection of the fetus begins prior to conception.

Infection

Infections and toxins in the mother affect growth and development of the embryo. German measles is the best known example. Drugs given to combat infection and for other causes are also becoming highly suspect as agents causing anomalies of reproduction (Bau, 1951).

Birth Process

A significant number of birth injuries cause bring damage resulting in disorders of emotion, intellect, and behavior as well as physical disorders.

Anoxia at birth and high bilirubin levels may produce brain damage with resultant physical disorders. Effective prenatal care with emphasis on both physical and psychological preparation of the mother can help reduce birth trauma.

Prematurity

Prematurity is sometimes a major crisis in the life of a family. One follow-up study on prematures over a ten year period showed emotional maladjustment to be a more common sequelae than physical handicap (Drillien, 1964). Parents, particularly the mother, should be encouraged to handle and feed the infant in the premature nursery as soon as his physical condition will permit. This will enable the mother-child relationship to become a reality and relieve some of the mother's feeling of ambivalence and fear which later can lead to overprotection of the infant (Caplan et al., 1965).

It has been shown that early and consistent prenatal care reduces prematurity. Women with poor nutrition and/or low socio-economic standing, and unmarried mothers as well, have higher prematurity rates than the population at large.

Teenage Pregnancies

An increasing number of pregnancies are occurring in teenage mothers, both in and out of wedlock. These mothers are a high risk group in relation to fetal anomalies. They are also struggling with adolescent emotions and both marriage and pregnancy may be a result of rebellion against adult authority (Adams, 1963). Family life classes in school with emphasis on the meaning of sexuality and not just the biological facts of reproduction would be one way of educating this group before pregnancy occurs. The importance of nutrition in family health should be a part of such education.

Services Needed by Zone I Population

Casework Services

Social casework services, particularly to economically deprived families and those identified as having serious mental and emotional difficulties, need to be increased. Other requirements include: better liaison between the caseworker and the other members of the health team; referral of pregnant women to prenatal clinics at an early stage; premarital counselling to prepare men and women for the roles of husband, wife and future parents.

Medical Services

In Alberta, services are available to all prenatal patients regardless of income, yet frequently they are not being used early in pregnancy.

Outpatient clinics, while giving adequate physical care, generally do not create an awareness of the psychological concomitants of pregnancy and delivery. Social worker services are available but are not used fully. Physicians and nurses need training to recognize patients who need education and counselling for parenthood. Clinic hours should take into consideration the needs of the working mother.

Education

Currently available information about family life, pregnancy, and parenthood should be disseminated to professional health, welfare, and education workers; to the general population and to persons with special risk of producing mentally and emotionally handicapped children. The current "education for parenthood" classes need to be re-examined. Ways of motivating the lower-income groups to acquire more knowledge must be found if the dangerous gap between what is known to the medical profession and what is practised is to be narrowed.

Provision of Non-Psychiatric Resources

If the flow of people to Zone IV is to be kept to a minimum, current services to the Zone I population must be maintained and in many instances improved. Additional services which contribute to healthy growth and development and future mental health must be developed and made available. The following factors should be considered:

1. A redefinition of the nurses' role in prenatal care with greater emphasis on psychological care of the mother, as follows:
 - a) Use of a public health nurse for prenatal visits to mothers in their homes.
 - b) Change in existing prenatal classes to allow discussion of problems rather than a didactic presentation of content with emphasis on psychological and emotional implications of pregnancy and delivery.
 - c) Using a nurse in the outpatient clinic to do prenatal teaching as the expectant mother waits to be seen. Rapport and continuity of care with one person can thus be established.
2. The public health nurse and the social worker should work in closer liaison to seek out those who do not obtain early prenatal care.
3. Prenatal clinic hours should be scheduled in part in the evenings so working mothers and mothers with large families may attend early in pregnancy.

4. The nurse could carry out regular prenatal visits and provide physical care and health teaching in the home or in a local center with the patient seeing the doctor only at a first visit and during the last month unless complications occur or are present during pregnancy. This procedure could ensure earlier and more regular care for some mothers.
5. The school nurse and the public health nurse should be educated so that they can both teach and act in a consultative capacity on family life education. Such education should begin in elementary school and be continued throughout the curriculum.
6. Information on marriage counselling services must be more widely disseminated. Young couples contemplating marriage should be encouraged to attend. Nurses, doctors, and social workers, all have a responsibility in this area.
7.
 - a) A relaxation of rules in premature nurseries is desirable so parents may visit their baby frequently. Nurses should allow the mother to participate in the care of her baby, holding and feeding him as soon as his condition permits.
 - b) A mother with premature infant should be visited by a public health nurse while the baby is in hospital, allowing the mother time to express her anxieties and work through her own feelings before the baby comes home.
8. The provision of homemaker services for teenage parents, to facilitate the adjustment to parenthood, should be available as needed.
9. The dissemination of information of planned parenthood should be a responsibility of every member of the health team, including the nurse.
10. There must be greater cooperation between all members of the health team, doctor, nurse, social worker, and dietician, with full information available to all, if prenatal care is to be optimal. Too often now, care is fragmented and duplicated.

Proposals and Recommendations

Consultation

1. Mental health consultation should be made available to pre-maternity centers, parenthood classes, prenatal clinics, obstetrical services, health education institutions, premarital and prenatal counselling services, and homemakers' services.

2. Such consultation should be provided by qualified professional mental hygiene personnel (psychiatrists, clinical psychologists, psychiatric social workers, and nurses).
3. Such consultation should include program planning, staff development and special problems in the non-mental health agency's caseload which appear to have mental or emotional implications.

Education

1. Nurses working in the public health agencies and prenatal clinics should be well prepared in the area of mental health.
2. Nurses should be prepared to participate in the planning and implementation of parenthood education.
3. Nurses should be prepared to participate and give guidance in the implementation and planning of family life and prenatal classes

Zone II

Zone II persons are those born healthy and able, with resources of society to develop and maintain themselves as they move toward added responsibility and independence.

This group derives help from a variety of persons or facilities but manages to get along with formal professional help.

Caplan (1959) states:

"...If we can apply measures to guide and strengthen vulnerable, but 'normal' people in meeting the opportunities and challenges and obstacles in life, we can succeed in reducing the incidence of mental illness."

The role of the nurse with Zone II is primarily one of education.

1. In contacts with families on request or regularly the nurse gives information about normal growth and development and possible signs of illness to children, adolescents, and older folk.
2. In the schools the nurse could assist to set up programs of health education and on occasions perform a counselling role. Her special interpersonal skills might be of assistance in:

- a) Parent-school relationships
 - b) Parent-child relationships
 - c) Adolescent groups
3. At schools, churches, jobs and recreation facilities the nurse might assist adults into marriage, parenthood and retirement and help establish enlightened attitudes toward mental health and illness.
 4. In industrial health departments the nurse has a role in the identification of problem areas and the promotion of good health practices.

Zone III

People in Zone III need special help beyond their own capacity, i.e. general medical care, economic aid, legal assistance, help with broken homes and unemployability. Their needs may produce extraordinary stress, fear and anger. The stressful situations are classed here as "non-psychiatric" troubles instead of disorders because they evoke "normal" reactions. The caretaker's challenge is to prevent their deterioration into mental disease. (from Lytle, 1967).

Zone III nursing functions are located in hospital settings; in public health units and departments; in doctors' offices; and in various community agencies (e.g. recreation facilities and child care agencies).

Some of the nursing functions are clear and primary as in hospitals and health departments, but in other community agencies, such as prisons and training schools, there is less clarity.

In hospitals the nurse assists patients in dealing with anxieties due to illness, grief, child separation, death and fear of unknown. Through liaison with the public health nurse she aids the patient in making a readjustment back to the community. With the aged she helps rehabilitate older patients following illness; maintains liaison with community agencies; assists in screening of patients for care; and helps with placement away from home.

In health departments, she has a preventive and a teaching role in stress situations, i.e. immunization, well-baby clinic, pre-school children, and with school children, testing for vision and hearing disabilities. She is frequently in a position to recognize possible difficulties and play a preventive role.

In a doctor's office, the nurse is in a position to identify problem areas in an informal way. Sometimes nurses perform as counsellors or liaison staff, i.e. public health nurses form liaison with welfare department facilities from the hospital. In child-care organizations (e.g. for crippled children or orphans) nurses frequently engage in care and treatment

with implications for attitudinal and personality development. In working with probation departments, public health nurses can be a link with school, family, and other community agencies. The nurse working with Zone III people should try to recognize and refer problems to appropriate resources because she becomes aware of many in her daily contacts.

Proposals and Recommendations

1. That nurses be hired more generally for liaison between hospital and community on the basis of one in every treatment facility of 100 beds or more.
2. That services for the aged be coordinated with special attention given to careful screening of elderly people, done by a specially prepared assessment team, including nurses, in conjunction with family and friends.
3. Care should be in the home if at all possible. "Dumping" the elderly in mental hospitals should cease.
4. When placement of the aged must be outside the home, physical facilities should be attractive and planned specifically for elderly people with allowances for socialization, recreation, physiotherapy, and rehabilitation.
5. When nursing care of geriatric patients is advised, the nursing service should be under the direct supervision of registered nurses with special preparation.
6. Mental health concepts must be immediately integrated into present nursing curricula so nurses will be prepared to meet the needs of patients under stress.

Zone IV

Zone IV includes persons with mental illness, including alcoholism and other addiction, and mental retardation to such a serious degree that they need clinical services. This disordered population is composed of those individuals in Zone I whose birth, genetic inheritance, fetal development or reaction to birth has developed in them sufficient symptoms to warrant a diagnosis of psychiatric disorder; from those in Zone II who have developed such symptoms; and from those in Zone III who require clinical services for corollary emotional problems.

It is sometimes stated that one out of every ten persons at some time will suffer from psychiatric disorder. One out of every four individuals has problems for which professional help would be useful; and one out of every seven actually seeks such help at some time during his life. If we

project these figures for Alberta in 1981, when it is expected that the province's population will be two million, 200,000 individuals will have during their lives a psychiatric disorder. During their lifetime, 400,000 will have problems for which professional help would be useful, and 285,714 will actually seek help.

The need for mental health services each year will increase and mental health services will have to be strengthened. Concurrently, new patterns of care must be developed so that more disturbed persons can receive more effective help, quickly, and under realistic circumstances. These new patterns are discussed later in this chapter.

Comprehensive care for the mentally disordered (Zone IV) would include:

1. Doing everything proper to keep an incipient patient out of hospital,
2. Giving care and treatment in hospital with the goal of discharge at the earliest possible date, and
3. Providing services needed after discharge to effect reintegration into family and community life, re-employment, and prevention of a recurrence of the illness.

Comprehensive care would involve:

1. Non-mental health agencies providing residential services, services at work, and in connection with physical, financial, educational and recreational needs. Facilities would be non-hospital, not involving psychiatrists but would depend on the staff of social, health and educational agencies or units.
2.
 - a) Clinics for adults and children with staff limited to psychiatrists, psychologists, social workers and nurses.
 - b) Psychiatric units in general hospitals with a bed capacity of at least 100, with medical doctors, including psychiatrists, nurses, psychologists, social workers and recreational and occupational therapists.
 - c) Mental hospitals for intensive treatment, not exceeding 300 bed-capacity, similarly staffed.

Limitations of Present Resources

The majority of existing facilities are clustered around Calgary, Edmonton, and Red Deer. However, most individuals in outlying areas have to travel to obtain psychiatric aid and often find themselves confronting insurmountable discomforts and dislocations.

Services available to the early stage Zones (I-III) are minimal, and Zone IV services are hampered by lack of trained staff.

There is limited inter-relation of services and there is evidence of fragmentation of diagnosis, treatment, and rehabilitation services.

Special Problems in Alberta's Mental Hospitals

Nurses in Alberta Mental Hospitals are unable to provide the necessary quality and quantity of service. A lack of well-defined admission policies has resulted in the occupancy of active treatment psychiatric beds by the aged, the physically ill and a transient group of patients with behavioral or situational problems.

Wards are large and crowded with little room for patient grouping. Architectural standards are in sharp contrast with the standards of the Nursing Home Act where size, site selection, corridors, ramps, stairways, heating, ventilation, windows, toilets, bathrooms, and sleeping and living areas are specified in detail. Further, these specifications do not apply for the geriatric patients in a mental hospital.

The chronic national problem of staffing exists in Alberta in emergency proportions. Less than the required number of nurses and limited preparation are the primary deficiencies. The graduate nurse is cast in the role of teacher and supervisor but her basic education has not prepared her for those roles.

Other factors further accentuate the nursing shortage, including:

- Absence and illness rates (During March 1968, at the Alberta Hospital, Edmonton, a total of 200 shifts were not worked because of female ward staff's illness or absence; 200 shifts amount to 1600 hours of care.)
- Staff turnover (In a 12-month period from April 1967 at the same institution 277 nursing and auxiliary nursing personnel terminated service and replacements tended to be less well prepared.)
- Inclusion of students as staff
- Less than adequate support staff (e.g. housekeeping, ward clerks, porters)
- Inadequate equipment
- Defective personnel policies.

A nursing budget does not exist and the nursing administration is unaware of how staff quotas are set or reduced and how priorities are determined for the provision of supplies and equipment.

The Civil Service evaluation form is used to appraise nursing performance and it is not appropriate.

Nursing is unable to relate its philosophy, objectives, and policies to those of the mental hospital and the Division of Mental Health because written copies of the philosophies, objectives, and policies of the hospitals and Division of Mental Health are not available.

General Guidelines for Services to the Psychiatrically Disordered

1. Patient Needs

The needs of the patient are primary and should not be put aside because of clerical or administrative pressures.

2. Continuity and Availability of Service

- a) There should be a maximum of continuous personal contact and a minimum of transfer from one therapist to another, or from one agency to another. Treatment should begin at the moment of first contact and continue throughout. The process of separating intake from diagnosis, diagnosis from treatment, and treatment from after care should be avoided.
- b) Services for diagnosis, treatment, rehabilitation, and follow-up should occur within the living radius of the patient, and with sufficient facilities and trained personnel.
- c) Care and treatment after hospitalization is essential to assist the patient to become re-established in his home, occupation and community.
- d) Problems cannot be met by increasing psychiatric services, an impracticable proposition; the manpower requirements simply cannot be met. What is needed is not more of the same, but something quite different. Continuing research, experimentation, and inventiveness are needed to develop new methods of providing mental health services to people in trouble.

3. Identification of Psychiatric Disorders

- a) Initial screening to determine whether a person has a psychiatric disorder should be carried out in general health and welfare facilities, not isolated from other services in the community.
- b) A positive approach to case-finding must be made by provincial, local, and private agencies in the same way as problems other than mental illness are identified.

- c) Referrals to appropriate mental health agencies should be made when an individual is found to have a psychiatric disorder.
- d) The establishment of a diagnosis, a medical responsibility, must include the judgments of others if evaluation is to be complete.
- e) The effects and impressions the diagnosis makes on the person, his family and friends and the community should be considered at the time of initial screening.

4. Implementation of Services

- a) The concept of long-term and short-term hospital beds for persons with psychiatric disorders is obsolete. As long as hospitalization is needed, intensive treatment is implied. If intensive treatment is not needed, hospitalization is not necessary.
- b) Individual treatment, in small units with adequate privacy should be the aim.
- c) Immediate means for intervention must be made available, particularly pre-crisis intervention.
- d) Emergency hospitalization must be available for all age groups.

5. Follow-up and Allied Services

- a) Special education and training are sometimes required to assist an individual to make new adjustments.
- b) Appropriate residences for ex-patients in small living units suited to the individual's needs are necessary parts of rehabilitation programs.
- c) Availability of employment suited to the individual's abilities is essential in a total rehabilitation plan.
- d) Close liaison between clinic, hospital, and agency, as indicated, is necessary for rehabilitation.

Special Guidelines for Emotionally Disturbed Children (Cont'd)

1. Organization and Location of Treatment Facilities and Services

- a) Adequate provisions, including specially trained personnel, must be made to serve children in outpatient facilities.
- b) Treatment services in hospitals also are required for children and they must include emergency services. The number of children's beds requires further study.

- c) Treatment programs for children must consider ties to the family and facilities must be located near their homes.
- d) Contact with other children is necessary for Zone IV children to develop ability to live with others.

2. Residential Services

- a) Protective residences for children are necessary. These should emphasize therapy, even as emergency facilities, for about 72 hours while return of the child to his home or a suitable placement can be arranged.
- b) Residential treatment facilities for children should be small.
- c) Specially selected and supervised foster homes for Zone IV children are important adjuncts to any treatment service.

3. Education

- a) Small classes for retarded and emotionally disturbed children in public school systems are necessary. Teachers must be provided in inpatient settings as well.
- b) Zone IV children need individual attention which can best be provided through small classes or separate classes. Special consultative resources and special training for teachers are required.

4. Other Services

Other children's services required are: specially designed religious counselling, recreation facilities, and financial aid programs, such as Aid to Needy Children, for parents to allow care in the home and avoid dislocation of the child.

Special Guidelines for the Aged

The 1965 census revealed 104,010 persons in Alberta who are 65 years of age and over, seven per cent of the population of the province, and a number likely to triple by the year 2,000.

The following services for the aged in Zone IV require consideration.

- 1. Because of increasing physical illness, thorough diagnostic work-ups are necessary; early treatment of a physical problem may preclude hospitalization for psychiatric disorders.

2. The patient's dignity and identity should be given particular consideration because of specialized problems of social relationships.
3. Correction of individual economic and social deficiencies would allow for individualized care more suitable to their needs than hospitalization in present psychiatric facilities.

Sexual Offenders

Treatment for offenders whose sexual behavior is a symptom of underlying disorders should take place in a psychiatric facility where the development of scientific understanding should be an important orientation. Courts need help from mental health professionals in identifying such offenders as distinct from persons who would be properly isolated in correctional institutes.

Qualifications of Nursing Personnel for Zone IV

Three levels of qualification are considered necessary.

1. The psychiatric nursing specialist with a baccalaureate degree as a minimum, preferably a master's degree, prepared to plan and give direct and specialized care, supervise and teach.
2. The general staff nurse with R.N. or R.P.N. qualifications, possibly a baccalaureate degree, prepared for basic and technical nursing duties in a psychiatric setting.
3. Non-professionals, including aides and orderlies, who are prepared to give bedside care, offer companionship and carry out simple medical, surgical and routine ward procedures.

Community Care

The purpose of this section is to indicate how nursing can contribute to community-based treatment for the mentally ill. The general position will support the desirability of treatment close to the individual's social setting.

Any resident of the province should be able to receive attention for a mental health problem by travelling not more than fifty to seventy-five miles. The absolute minimum services available should be diagnosis and referral, twenty-four hour inpatient care, outpatient care, and follow-up services.

That standard would require development of the above services in the Medicine Hat and Peace River regions where minimal service is provided on a part-time basis. Expansion of the mental health services in the Red

Deer and Lethbridge areas would also be required, probably through expansion of the Guidance Clinic services and the development of inpatient care at general hospitals. Guidance Clinics should develop an increasing liaison with health unit staffs whose programs should be broadened to include more activity in the mental health field. This may suggest the employment of nurses in guidance clinics, or alternately, nurses in health units as liaison people with psychiatric resources. Nursing personnel working on inpatient services should be exposed to situations where they can gain a broader understanding of the social and family life of their patients in hospitals in the interest of continuity of care, which is so necessary if treatment is to be successful.

Within the general hospital, nurses with psychiatric specialization should be used in a teaching capacity to help achieve a more general understanding of mental health principles and techniques. In this respect it is suggested that increased emphasis be placed upon practical human relations education in contrast with exposure to traditional psychiatric categories and conditions.

If a nurse, or any mental health professional, is to function effectively, an understanding and acceptance of the complementary professional roles is essential. At present, arbitrary and unnecessary limitations appear to be placed upon various members of the mental health team. It is suggested that interdisciplinary committees at all levels should examine this matter with a view to achieving change and improvement.

Implications for Nursing Education

There is a need for nurses who are skilled and qualified to form helping relationships with patients, guide non-professional staff, and give leadership to nurses working in non-mental health agencies.

How is the overwhelming need for qualified nursing personnel, in the field of mental health, to be met? In order to answer this, it is necessary to examine present provisions in Alberta for preparing nursing personnel to work in mental health agencies. Three kinds of programs are in operation: one for psychiatric and general nurses (Alberta Hospital, Ponoka); a second which graduates the R.N. from diploma programs throughout the province; and a third which trains psychiatric nurses (Alberta Hospitals, Ponoka and Edmonton). The first two programs are consistent with standards set by the Nursing Education Committee, Universities' Coordinating Council, while the third is not organized under an educational authority, but is controlled by the Government under the "Psychiatric Nurses' Training Act." Nurses from the three programs are being employed in some areas where they are given the same responsibility and remuneration although their qualifications are not the same. Dr. Mussallem (1964) has observed that:

"...it is recognized that a situation in which two groups work autonomously and independently in the same general area has within it the seeds of confusion, conflict and controversy."

Nursing specialists in psychiatric services should be prepared in either the post-graduate program or in the psychiatric-general nursing program, both conducted at Alberta Hospital, Ponoka. However, other action is needed because the graduates from these programs, as well as diploma R.N.s interested in psychiatric nursing, do not fill the present needs of nursing in the mental health field.

There are several considerations which influenced the recommendations to be made about nursing education. First, the educational policies set out by the A.A.R.N. and the C.N.A. have been observed:

"...that nursing education programs...be conducted within the framework of general education in the province."

"...that there should be two well-defined categories of nurses:

- (a) the nurse prepared in a university program leading to a baccalaureate degree in nursing.
- (b) the nurse prepared in a programme leading to a diploma in nursing in educational institutions such as junior colleges and community colleges."

Secondly, it is considered educationally sound to teach basic skills before specialized skills, so curriculum content should proceed from the normal to the abnormal.

Last, if the best use is to be made of staff there will have to be provision for continuing education programs for staff in the treatment facilities and within the provincial service.

Recommendations on Nursing Education

Intermediary Steps

1. That nursing education come under the direction of the Department of Education. This control of education at provincial and hospital levels should offer higher quality educational programs of short length. It is hoped this:
 - a) would attract greater numbers of more highly motivated students;
 - b) would more than cover any loss of incentive incurred by eliminating the service payment;
 - c) would better fulfill service needs by providing more, better educated graduates, in a shorter length of time.

2. That direction for nursing education be a responsibility of nursing educators in consultation with medical doctors.
3. That students being educated in the psychiatric hospitals be taken out of the service complement.
4. That the present Schools of Nursing have a budget separate from that of the hospital nursing service.
5. That the monies now paid to psychiatric and basic students be re-assigned to a fund made available to students in the form of bursaries, grants, and loans.
6. That the present four-year combined general and psychiatric nursing program be shortened to three years.
7. That the educational facilities be immediately improved and expanded at Alberta Hospitals, Ponoka and Edmonton in order to meet immediate and urgent needs.
8. That these new facilities be adequately staffed with educators, librarians, and stenographers.
9. That the educators consist mainly of nursing educators but also include assistant lecturers from the areas of psychiatry, psychology, social work, and occupational therapy.
10. That the present post-basic program be discontinued at Alberta Hospital, Ponoka and that university courses take its place when:
 - a) provision has been made by the universities of the province for nurses from basic nursing education programs to obtain clinical specialization in psychiatric nursing, and when
 - b) sufficient numbers of nurses have been attracted and graduated from such programs.
11. That scholarships, bursaries, and loans be increased in number and amount to registered nurses for educational programs in the mental health nursing field.
12. That financial assistance to the post-secondary institutions of higher education be increased to accommodate future expansion of their programs and research development.
13. That a degree program at the baccalaureate level be established to lead to a Bachelor of Nursing (with a major in the social sciences, including psychiatric nursing).

14. That post-secondary educational institutions provide programs in psychiatric nursing for both R.N.s and P.N.s who meet entrance requirements.
15. That a qualified nurse-consultant be employed to study educational needs in the area of nursing in the mental health field with a view to planning beyond these intermediate steps for future needs.
16. That opportunities be provided for psychiatric nurses to obtain preparation in general nursing in programs specially designed to meet the immediate needs of the mental health services.

Future

That the new educational facilities recommended for construction at Alberta Hospitals, Edmonton and Ponoka, be made available to students, who will need clinical experience in their study of nursing, psychology, medicine, social work, and occupational therapy.

Ultimate Goals

1. That the long range goal be toward a basic undergraduate education in nursing as outlined by the A.A.R.N. education policy statements, with mental health concepts integrated into the curriculum.
2. That the universities develop a post-baccalaureate degree program in mental health nursing.
3. That refresher courses and extension courses be made available to graduate nurses.

Implications for Nursing Research

The urgent need for research in nursing is made evident by the rapid turnover of staff and a generalized dissatisfaction in attempting to meet patient needs. Part of this need in the psychiatric realm, is quite probably due to the changing role of the nurse from a custodial emphasis to a therapeutic emphasis. As in so many areas, theoretical knowledge in psychiatric nursing is growing far ahead of its application and the need for prepared staff is growing rapidly. This gap is applying much pressure to those involved in the mental health field and the necessity for change is very evident. What changes then, can be made to alleviate the ever increasing stress? Research would in fact help to identify problems and lead to possible solutions.

Areas of possible research include: definition of roles of different kinds of nurses; patient needs in relation to preparation of nurses for mental health services; determination of nursing manpower needs, including requirements for teachers, administrators and clinical specialists; R.P.N.-R.N. training and inter-group transfers; extended use of nurses in community care.

Recommendations on Research

1. That a position for a research director be made available in the Department of Health, and that funds be made available to individuals desiring to do projects in the areas of psychiatric nursing.
2. That a coordinating agency be set up at provincial and federal levels to file (according to subject matter and area) the research projects in progress and already completed thereby preventing wastage of valuable resources.
3. That studies be undertaken to determine the quantity and quality of nursing care required in the mental health field so as to make the best use of personnel available.

Requirement for Nurse Consultants

There are two major areas in which nursing consultation would prove useful to the Government: nursing education (both graduate and undergraduate) and nursing administration. However, of even greater importance would be the coordination of the two to better the quality of patient care. One might envision nursing consultants in every region who could in turn communicate with a nursing consultant in the Department of Health who could coordinate the total efforts being made in the province. This person would then be in a position to provide the Department of Health with a total picture of nursing needs within the Province.

With specific reference to psychiatric nursing, consultation would be valuable in these areas and contexts.

1. Education

- a) To study the overall need for prepared people in the area of psychiatric nursing, the qualifications necessary to meet provincial needs and the financial assistance necessary to meet those standards.
- b) To help determine how best to upgrade and maintain present nursing staffs.
- c) To advise staff in schools, hospitals, health units, industry, and health centers.
- d) To advise schools of nursing regarding the incorporation of mental health concepts into their curriculum.

2. Nursing Administration

- a) To help establish high standards of patient care and attain some degree of standardization.

- b) To help ensure economical and effective use of staff.
- c) To advise regarding the role of administration in inservice education of graduate staff.

3. Coordination

To coordinate the psychiatric nursing services through the province.

Recommendations on Coordination

- 1. That a Nursing Mental Health Consultant be appointed within the Department of Health.
- 2. That Nursing Consultants be hired for each Health Region, with coordination of efforts made by the Department of Health Consultant, in the interest of making immediate improvements in the availability of mental health consultation to general hospitals, public health agencies, and other community health agencies.

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PSYCHIATRIC NURSES ASSOCIATION OF ALBERTA

Introduction

Problems of care for the mentally ill in the Province of Alberta are: too many patients for existing facilities; and too few trained staff to administer effective treatment. The public attitude here towards mental health is not unique.

The Royal Commission on Health Services, 1964, and More for the Mind, 1963, have emphasized that the mentally ill patient does not receive care comparable to that provided for the physically ill.

The great need for effective psychiatric and mental health services in Alberta is acknowledged by this Association and we accept the responsibility of making known the needs of patients and the needs of the nursing profession in that regard.

There has always been a great need for a special kind of nursing care for the mentally ill. The psychiatric nurse requires special skills and knowledge, much different than those required for treatment of the physically ill. To answer this need, in-service training of largely untrained hospital staff in Alberta's mental hospitals was started in 1930.

Today, the resulting special kind of nurse is still unable to provide the kind of attention the patients require. In 1968, psychiatric nurses are generally an unhappy and dissatisfied group, due to factors hindering the proper practice of their profession.

On completion of their three-year basic course, they take a pledge to give their whole-hearted service to their patients. At present, the existing facilities and services do not allow them to fulfill their pledge. The Association is taking this opportunity to meet their responsibility to fulfill the nurses' pledge and make the public and practitioners aware of the need for upgrading mental health services and facilities in the Province of Alberta.

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The following documents were used in the preparation of this brief:

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5. Nursing Education Survey Committee, Dr. Scarlett, presented May, 1963.

Original Research

In addition, an extensive survey was conducted recently by the Association among the more than 450 nursing personnel caring for the mentally ill in the Province.

Briefs were submitted to the Council from various treatment centers throughout the Province and these form the backbone of this brief.

Conclusions

Mental hospitals in Alberta are remote, isolated and far too large to provide optimum care for the mentally ill. They lack a well-defined screening policy. The care of most patients tends to be custodial in nature because of the lack of proper facilities and adequately qualified personnel to provide therapy. Pre- and post-hospitalization programs should be introduced to alleviate strain on current facilities and staff.

Understanding the mentally ill patient's individual emotional and physical needs is seriously hampered in the large mental hospitals because each ward is populated with people of varying kinds and degrees of illness.

The psychiatric nurse in Alberta can only develop pride and skill in her special field of nursing, if the attitudes in society toward the mentally ill and the nurses' contributions to their care are changed. The poor public image of the nurse is partially attributable to poor public information programs, but mainly due to the lack of trained leaders and management, the lack of progressive educational programs at the post-graduate and university level, plus the lack of financial assistance for post-graduate training.

These negative characteristics are hindering recruitment of new people and qualified people are leaving; thus patients can not be assured of adequate care. If better programs and working conditions are not provided soon, patients confined to mental hospitals may soon suffer the same neglect they did thirty years ago.

While the psychiatric nurse pledges to "respect the rights and privileges of her patients, and alleviate his physical and psychological discomforts," she finds it impossible to do so while working in a large mental hospital. Her need for tangible recognition for her services is not being met. Surrounded by dissatisfied co-workers and evidence of deficiencies, she often seeks greater job satisfaction elsewhere.

Recommendations

The Psychiatric Nurses Association of Alberta recommends:

1. That greater efforts be made at the high school level to encourage promising students to enter the psychiatric nursing profession.
2. That basic education programs for psychiatric nurses be standardized and left open-ended to allow the student to continue her education at a post-graduate level.
3. That new educational programs, both basic and at the university and graduate school level be developed and be specifically designed to meet the needs of students working in the mental health field.
4. That psychiatric nursing personnel be given more recognition for their services by improving their working conditions and a salary scale in line with other comparable professions.
5. That facilities be developed so that a mentally ill patient can be admitted to an area within the hospital that is designed to meet his needs.
6. That the number of auxiliary personnel be increased, thereby decreasing the nurses' non-nursing duties.
7. That the criterion for determining the number of nursing personnel be examined and brought into line with current needs.
8. That large mental hospitals be phased out and replaced with smaller regional hospitals of not more than 300 beds. More general hospitals should develop facilities to care for psychiatric patients, and pre/post programs and facilities should be introduced.
9. That steps be taken to establish more effective intra-hospital communications.
10. That male and female patients be integrated on the ward and cared for by male and female members of the nursing profession.
11. That a well-defined screening policy be developed so that psychiatric beds are occupied by disordered adult patients. Separate facilities should be developed for care of the aged, the addicted and the emotionally disturbed adolescent.
12. That present facilities for occupational therapy, recreational therapy and educational programs be expanded and staffed by qualified personnel.
13. That financial assistance in the form of bursaries or grants be made available for continuing education.

Currently the psychiatric nurse is striving for a transition from custodial to therapeutic patient care. This transition is difficult because the public image of a psychiatric nurse's duties is often confused. Recruitment of suitable candidates into the profession is affected adversely. The psychiatric nurse should be completely aware of her position and the definition of her work. Unfortunately, this is not the case in Alberta. No agreement has ever been reached on what should constitute the "ideal" role, and the psychiatric nurse is therefore unable to evaluate her performance.

Great stress is being laid on a team approach to therapy, and some of the prerequisites of effective team work are that each member shall appreciate where her own responsibilities lie and those of all other members of the team. Until the psychiatric nurse's rightful function is defined and activated, it is impossible to prepare her adequately for that function; and until she is adequately prepared, the chances of improving nursing care are negligible.

Psychiatric nurses in modern mental health practice must be thought of as functioning in three main areas:

1. Psychiatric institutional settings
2. General hospital settings
3. The extramural health services.

Her role must vary according to her position on the team and to her level of competence, which is related to the type of preparation she has received, at a basic, advanced and auxiliary level. Unfortunately, today, psychiatric nursing training is available in Alberta only at the basic level.

The nurse's role and her required skills must also vary according to where she is employed. For example, a nurse who works in geriatric wards of the mental hospital will be called upon more frequently to exercise her physical nursing skill than a colleague elsewhere whose patients require more recreational therapy. Nevertheless, the second nurse must be able to recognize physical illness when she meets it and must also be able to cope with any emergency. The nurse, when engaged in recreational therapy, must use great powers of persuasion and much tact to induce team cooperation. The nurse caring for geriatric patients, however, requires the same type of skill, but to a lesser degree, to persuade one individual to cooperate.

Basically, there are seven main types of skill making up the role of the psychiatric nurse. They are:

1. Basic nursing skills
2. Technical nursing skills
3. Occupational and recreational skills
4. Organizational skills

5. Interpersonal skills
6. Observational skills
7. Skills of communication with patients and co-workers.

The first three types of skills are more easily demonstrated and taught, yet the last four, which tend to occur at a more intuitive level, are considered of extreme importance and in differing degrees are essential to each grade of nursing personnel.

"Basic nursing" refers to meeting the needs common to all patients; "making the patient generally comfortable," illustrates the concept. Technical skills, as required by the nurse in mental health practice, may include: recording temperatures, pulse and respiration rates; giving injections, preparing instruments for diagnostic procedures, assisting with surgical operations, electro-convulsive therapy, or insulin treatment.

Occupational skills require sufficient ability to carry out non-medical treatments demanding a considerable degree of manual dexterity, such as typewriting, weaving, carpentry, etc. Recreational therapy may not be solely the nurse's responsibility. Once again, it is a useful medium for transmitting her therapeutic attitude through indoor and outdoor sports and the activities of societies and hobby clubs.

Organizational skills refer to the type of planning ability which ensures smooth running of the ward, accomplishes routine chores, and creates the type of atmosphere conducive to the patient's recovery.

There is an increasing tendency for the nurse to be responsible in a psychiatric hospital, not so much for just the exercise or feeding and arrangements of all patients, but rather for the overall care of a smaller group. One of the important parts of the nurse's function, therefore, is to determine what constitutes a meaningful activity for patients in her care.

The nurse in mental health practice must also possess a warm, responsive personality. She is constantly interacting with the patient, as well as with other members of the treatment team. Her responses to the patient are controlled and therapeutically oriented. Besides having knowledge of medication, she must have the skill to persuade a patient to take the medication. Her familiarity with the patient's reactions and sensitivity to his needs enables her to encourage him to cooperate in his own interest.

The nurse may also help to improve patients' relationships with each other and with the mental health team. She intervenes tactfully in quarrels of patients, encourages them to work together harmoniously, and supports the shy in their attempts to mix with others. Sometimes, she may also act as a bridge between patient and doctor.

Observational skills are exceedingly important for both the physical and psychological aspects of nursing care. Before the nurse can detect the abnormal in either sphere, she must possess a sound knowledge of what constitutes the "normal," in general, and with regard to any one patient in particular. The nurse must be alert to recognize clues to the state of a patient's mental health which are provided by his verbal and non-verbal attitudes, beliefs and fears. Her observations are useful in assessing progress and in determining the next stage of treatment.

There are basically two types of special communication talents required by the psychiatric nurse. The first is between the nurse and patient. The patient communicates with the nurse by means of words, looks and posture, consciously and unconsciously. The nurse in mental health must herself be able to communicate in a variety of ways. Written communications between the nurse and patient are comparatively rare but with increasing responsibility for extramural work it is probable that she may have to communicate by letter more frequently. A community mental health nurse may wish to arrange to visit a patient after his discharge from hospital. She thus must have a sufficient command of language to convey her meaning precisely because her letter may well affect the conduct of the interview.

In hospitals or in the community, the nurse is often called upon to explain to the patient and to relatives, sometimes even to the patient's employer, the rationale of any specific illness, presupposing both technical knowledge and the ability to communicate effectively.

The nurse's communication with the team may also occur at the same three levels - written, verbal and non-verbal, in a two-way process just as with the nurse-patient communication. Even professional nurses in mental health practice must take care to avoid misinterpretation. The most significant value of communication between members of the mental health team is to maintain good morale, and encourage group cohesion. As a result of her intimate contact with the patient, the nurse may have to coordinate and balance the contributions of each of the other disciplines, without dominating the discussion.

The preceding material is a surface attempt to survey the role of the nurse in mental health practice and to indicate the type of skills she needs. Two points should be stressed. First, the nurse has many functions to perform: listener, educator, technical assistant and coordinator, depending on the people with whom she is dealing at any one time and her own degree of professional skill. It is essential that she be sufficiently flexible to assume each function as circumstances dictate. Second, the psychiatric nurse must be able to use her skills with an awareness of their deeper significance for patient and nurse, in their relationship with one another.

The Psychiatric Hospital

In the past success in running a ward was judged by conformity of patients to a preconceived and rigidly determined pattern. The modern trend must be to emphasize much more the value of a permissive atmosphere which allows individual expressions of disorder to become overt, and thus more easily treated. Even with regard to restraint, which in modern psychiatric practice is more often chemical than physical, the reaction of individual patients must be carefully noted so changes in treatment may be made as necessary. The ability to recognize and utilize the therapeutic potential of a specific situation for a specific patient must be considered as one of the foremost attributes of the effective psychiatric nurse. The old-fashioned conventional relation between doctor and nurse, where the subservience of the latter was the principal feature, must now be changed to develop a new type of relationship in which each possesses a genuine respect for special skills of the other, but is aware at the same time of the complementary nature of the two roles. The traditional hierarchy of the psychiatric hospital must be modified with the nurse accepted as a full member of the mental health team, her responsibilities including treatment of the patient and functioning as a "liaison officer" between the patient and the team as a whole.

Public Attitudes in Alberta

The "ghetto" attitude to mental illness has prevailed in Alberta far too long. Large, self-sustaining communities of the mentally ill exist in remote geographical locations, presenting many problems, not the least of which is transportation difficulties for the patient, his relatives and the staff.

The community's attitude is also reflected in the segregation of the mentally ill, locked doors and by number of long-term patients in the hospitals. Many of the patients could function in the community if there were adequate facilities to help them make the transition from institutionalized living to community living. The lack of facilities reflects the reluctance of the public to accept and take the patients back into the community.

The inadequate staffs of mental hospitals and the lack of recognition given the psychiatric nurse outside of hospitals is a further reflection of the community's attitude.

The presence of dead-end educational programs for psychiatric nurses and their subsequent lack of recognition act as serious deterrents to attracting people to this field. Improved, open-end educational programs, accompanied by public information are necessary to attract people to the field.

The thinly disguised stigma attached to mental illness and to those caring for them is seen by the psychiatric nurse as the greatest barrier between herself and her patient.

Limitations Imposed on Psychiatric Nurses

The physical setting of the psychiatric nurse is much too large and over-crowded. This observation applies not only to the hospital as a whole, but to each ward within the hospital. Because of the number of patients in each ward, the nurse can not concentrate on the individual differences and needs of her patients.

If a person develops a physical illness that requires hospitalization, he will be assigned to an area in the hospital where there are adequate special facilities to care for him. His treatment program will be under the supervision and guidance of qualified personnel. All aspects of his nursing care will be geared to restoring his body so that he can again function in the community. If, however, a person develops a mental illness that requires hospitalization in a mental institute, he will be assigned to an area where there is a bed for him. His treatment program may or may not be under the supervision of qualified personnel. Even where qualified personnel are available, the range and variety of illnesses are such that it is impossible to meet the needs of individual patients.

Working conditions and salaries are causes of job dissatisfaction among psychiatric nurses in Alberta and they require attention.

The recommended staffing ratio is one nurse to five patients. Nurse-patient ratios in Alberta range from one to nine; frequently the ratio reaches one to twenty.

Performance of non-nursing duties is a condition of employment. Clerical work, housekeeping duties and porter services take up more than one-third of the nurse's time in Alberta Mental Hospitals.

Responsibilities must be carried out differently, depending upon the proportions of staff to patients. Another influence on the performance of the nurse is the number of other personnel employed. If there are few or no domestic workers, the nurse has to perform more domestic duties. Such activities, now frequently the responsibility of nurses, should be carried out by less skilled persons, not only for economic reasons, but because the nurse is left with insufficient time for therapeutic activities with patients, her primary task.

In one Alberta hospital 378 nurses, caring for 1,500 patients can provide only 1.4 hours of care per patient per day. To provide a safe level of care for patients, it was estimated by the nurses working in the area that each patient requires a minimum of 3 hours care per day.

Budget appears to be the main criterion used to determine the number of nursing staff to be employed in the mental hospitals. . Another consideration should be the patients' needs.

Although group therapy and activity can be effective the best use implies a recognition of, and respect for, the individual patient. Recognition implies knowing something about what factors are unique in each and remembering what they say. Respect implies the easy ability to see each patient as a person, to take him seriously into account rather than merely tolerate him, and manipulate him. If the nurse has sufficient time, the patient can find a person who offers him some security against ostracism, and help toward recovery.

The nurse is needed, because it is wise to talk to patients even when they do not answer conventionally, or do not even answer at all. But the nurse needs time and her time is frequently misused.

A patient entering the hospital has had a severe difficulty in living with others. He needs acceptance, close observation, and systematic study to establish what is wrong. The diagnosis may be physical, or social, or may be a blend of causes. Whatever the cause, because of the time spent with the patient, the nurse must be a crucial part of the treatment team in observation, reporting, and establishment of a contact with reality for the patient.

None of the above can be dealt with adequately if the nurse is involved in clerical and domestic duties to the exclusion of the patient. Under current conditions in Alberta, the psychiatric nurse must work inefficiently. Because of the lack of staff, both nursing and domestic, and extensive overcrowding the psychiatric nurse can not fulfill her pledge to: "understand the patient's individual emotional and physical needs and differences," nor can she do all in her power "to prevent or alleviate physical or psychological discomfort."

Overcrowding

In 1962 the Department of National Health and Welfare considered existing Canadian mental hospitals obsolete.

The two major mental hospitals in Alberta were constructed around the turn of the century and, although there have been some additions, these facilities are no longer adequate. For example, the last new building at the Alberta Hospital in Edmonton was opened in 1956 with a bed capacity of 104, fifty-two beds for each sex. The male ward has 85 patients now. In some of the older wards rated capacity has been exceeded by as much as 70%. Under these conditions, even the most dedicated nurse cannot give her patients adequate service.

The United Nations study on mental health and the Canadian study, reported in More for the Mind, as well as the Royal Commission on Health

Services, 1964, have reiterated what professionals have suggested for more than a century, that no mental hospital should have a capacity for more than 300 persons.

In Alberta, the major hospitals are attempting to care for 1,500 patients, often in buildings that are obsolete and inadequate even by minimum health standards. Examples of inadequate facilities include: buildings where there are only two bathtubs for 56 patients; four showers for 84 male patients; lounge facilities that double as dining rooms. Through extensive overcrowding, the psychiatric nurse cannot possible: "respect the personal rights and privileges of my patients," as she pledged to do.

Screening Policies

A lack of well-defined screening policies regarding the admission of patients has resulted in the occupancy of active treatment psychiatric beds by the aged, the physically ill and a transient group of non-mentally ill patients with situational problems.

Statistics for a five year period from 1960-1964 reveal that:

1. Active treatment psychiatric beds are being increasingly occupied by those patients with organic illnesses, particularly those associated with aging. Twenty-nine per cent of all first admissions were diagnosed as having organic psychosis. During the period from 1960-1964 this group increased from 16% to 27% of the hospital population. In 1955 they comprised only 10% of the hospital population. On December 20, 1965, patients over 65 made up 26% of the total patient population.
2. The mobility of patients in 1964 was the highest in history:
 - first admissions had doubled
 - readmissions had tripled
 - total separations approximately equalled all admissions
 - transfers-in had remained fairly constant while transfers-out had quadrupled
 - discharges and deaths had more than doubled.
3. The presence of a transient population with high mobility is indicated by the incidence of behavior disorders. Although they average only approximately 6% of the total patient population, they amount to 27% of all first admissions.
4. "Functional psychosis" accounts for approximately 63% of the in-patient population. As the majority of nursing personnel are required to care for the physically ill, the aged, and the transient behavior group, only minimal care is provided for patients with a functional psychosis, except during the acute phase of illness.

Within a broad provincial plan, the present hospital population could be reduced to patients who require care for major mental illnesses in the acute stage or, in the case of more prolonged illness, those with a prospect of recovery or improvement. Implicit in such a plan would be a screening and referral process which would provide the individual with appropriate care or treatment matched to his specific illness or problem.

Therapy

With the introduction of tranquilizers and anti-depressants in recent years, the nurse is able to restore the patient to a calmer state of mind and render him more accessible to other therapies. The nurse is not able to capitalize on this potential, however, because of the lack of qualified staff for other programs of therapy, such as occupational or recreational therapy and education.

In the case of education, patients lack proper classroom facilities and guidance of a qualified instructor. Rehabilitation of the patient would often be facilitated if he had the opportunity to go to school in a properly furnished classroom with appropriate audio/visual aids and a qualified instructor to guide him.

In 1964, 66% of the discharged patients were hospitalized for a period of three months or less. However, only 58% of the total patients discharged during 1964 were rated as recovered by medical staff. The remaining 42% of patients discharged in 1964 were rated as unchanged or improved. All these patients, and especially those rated as unchanged or improved, required a type of after-care that current staff and funds do not provide.

Requirements Outside Mental Hospitals

Crisis or emergency treatment facilities are needed. Sometimes a telephone answering service manned by a psychiatric team is enough to initiate treatment of people without hospitalization.

Many persons with psychiatric problems do not require 24 hours daily in hospital. Some can be treated in the daytime in day hospitals, or other facilities, reducing the pressure for hospital beds and dislocation of family life.

Some disturbed people are reluctant to give up employment to receive psychiatric treatment. Night hospitalization with release each morning in some cases can avoid interference with jobs and make available necessary treatment.

Following treatment in an intensive treatment psychiatric center, which is seen as only one sequence in an overall program, good after-care programs need to be available.

Many patients remain in hospital because they have no families who are in a position to accept them and many others, who have become institutionalized, require the protective environment of a suitable foster home.

Half-way houses based on an intensive treatment concept are a poor investment of staff and money in terms of the number of patients served and the alternative uses of such staff and money. However, half-way houses based on a room-and-board concept, with adequate follow-up services, add immeasurably to a mental health program.

People argue against half-way houses because they can degenerate into institutions and create dependency, rather than promote growth. There is evidence that both foster homes and half-way houses can fail in that way; however, with adequate follow-up services, both can serve the needs for which they were designed. The key is the provision of adequate professional staff.

Admissions to mental hospitals reflect the prevailing economic situation. When unemployment is high, admissions are also high. Rehabilitation requires that employment be available. Many patients do not have sufficient formal education to qualify for employment and do not qualify for training in existing vocational programs. The Canadian Vocational Training Program has been an asset; however, vocational assessment, sheltered workshops, and other training situations are needed.

The following features are required in a rehabilitation program for psychiatric patients.

- a. Follow-up psychiatric care, either directly or in consultation. This may include actual treatment, including drugs, psychotherapy, group or individual; or care from psychiatric social workers, medical practitioners or public mental health nurses.
- b. Careful attention to the family situation of the patient, either by working directly with the patient's family, or by the provision of home living for patients without families. The importance of providing a family setting is magnified after a long term in hospital accompanied by isolation of a patient from his family.
- c. Occupational placement, either through formal training or experience obtained in a sheltered workshop.
- d. Provision of adequate living arrangements.
- e. Encouragement of social participation.

Several urgent questions about rehabilitation are apparent and they require careful consideration. For instance, at what level and by whom should planning be undertaken? Who is to assume responsibility for implementation of plans? What are the roles of the hospital in-patient services; the out-patient services; the community clinics; the social agencies; sheltered workshops; and so on?

Education of Psychiatric Nurses

There is a critical distinction between the registered nurse and the psychiatric nurse. This distinction is most keenly felt in the area of education.

1. There are no post-graduate educational programs at university level for the psychiatric nurse in psychiatric nursing.
2. The only avenue open to the psychiatric nurse for self-development and entry into university is enrolment in a registered nursing school.

To capitalize on the post-basic programs now available, the psychiatric nurse must first qualify for registration in general nursing. There are only two hospitals in the Province willing to accept psychiatric nurses and prepare them for registration. The length of the program depends on the credit given for training already received. Only limited bursaries and grants are available and lack of adequate financial assistance seriously deters potential candidates.

Lack of advanced educational qualifications among psychiatric nurses impedes the development of leaders which, in turn, perpetuates a gap between the role of the psychiatric nurse and her level of preparation. The psychiatric nurse was for a long time the "keeper of the keys," giving custodial care only. However, it is becoming apparent that she can be of more value on the treatment team and must be able to prepare herself to take a more responsible position on that team.

THE VICTORIAN ORDER OF NURSES (PROVINCE OF ALBERTA)

Introduction

With the founding of the Victorian Order of Nurses in 1897, visiting nursing service was introduced into Canada. The organization has given leadership in the growth and development of this service and has contributed to the development of other public health nursing services in many communities. The original charter of the Order was replaced by an Act of Parliament, 1954, under which the Victorian Order of Nurses for Canada is incorporated. The present stated objectives are:

1. To establish, maintain and carry on a visiting nursing service in Canada and to aid in the prevention of disease and the promotion of health;
2. To establish, maintain and elevate standards of nursing service;
3. To assist in the preparation of nurses for public health nursing;
4. To promote the formation of provincial and local corporations or organizations having the same objectives;
5. To create branches of the Order.

These objectives indicate the Order's concern with care of the sick, prevention of illness and the promotion of health. They reflect an interest in developing and extending visiting nursing service, in maintaining its quality and in assisting in the training of personnel. The Victorian Order has always sought to plan and adapt its programs to meet the needs of a community. This has resulted in a variety of services being offered in many branches. Programs are planned in consultation with local and provincial health authorities and are carried on in cooperation with hospitals and other health and social agencies.

The primary function of the Order is to provide skilled nursing care to patients in their own homes, on a visit basis, combined with health teaching to the patient and family. This care is available in all branches to anyone in the community on a twenty-four hours basis for all types of illness, and to mothers and new-born infants.

Victorian Order services in Alberta were established in 1898 through small cottage hospitals, the first at Fort MacLeod. Later others were organized at Red Deer, High River, Isley, Edson and Athabasca. The Municipal Hospitals Act of 1917 set up the machinery for municipal hospitals and in 1922 the last Victorian Order hospital was turned over to the municipality at Athabasca.

Branches in urban centers began with Edmonton and Calgary, both in 1909. In 1947 the third branch was established in Medicine Hat and Redcliff, in 1955 one was opened in Lethbridge. Late in 1966 a branch was opened in Grande Prairie and in January 1967 a new branch was organized in Red Deer.

Present Facilities

Organization and Administration

The Order is a national, voluntary, public health organization with headquarters in Ottawa. Policies and standards are set at the national level and are accepted by all branches. The conduct of the affairs of the Order is the responsibility of a national board of governors and of boards of management and committees at the national, provincial and local level. This voluntary citizenship participation is a fundamental principle of the organization. The administration, supervision and development of the nursing service are the responsibility of the nursing staff of the Order. The structure of the organization provides for liaison between national, provincial and local levels. A group of medical consultants is available for consultation. The national organization coordinates the work at both staff and board levels into one organization with common objectives, standards and goals.

A provincial organization in Alberta was incorporated in 1956. The present six branches in Alberta are incorporated and each has a local board of management responsible for service and financing. Each board has a medical advisory committee, representative of the local medical society and local physicians.

Population and Area Served

The Victorian Order branches now serve a total population of 850,000 or 56.7% of the population in the province. Besides serving the corporate limits in each community all branches have extended service to adjacent areas and have plans for still further extension.

Program

Victorian Order service has been developed in cooperation with the local departments of health and health units. As there are variations in the programs offered by the official agencies and other health agencies, there are corresponding differences in the programs of the Victorian Order.

In 1967 nurses working in the five branches made 62,062 visits to 7,044 patients. Patients with medical and surgical conditions accounted for 78% of all visits. Although 61% of patients admitted for service were mothers and babies, only 21% of the visits were made to them. A statistical summary of service is shown in Appendix I.

In 1967, out of 3,422 patients discharged from Victorian Order service, 53 had diagnoses associated with a mental disorder. These 53 patients received 2,810 nursing visits. Most of these patients were under the age of 65 years and received all but 77 of the nursing visits. 1,581, or nearly one-half of all the medical and surgical patients (3,422), had been treated in hospital prior to receiving Victorian Order service. Of the patients with mental disorders, only 19 of the 53 had been hospitalized.

With growing emphasis on pre-discharge planning for the care of patients discharged from hospital a Victorian Order nurse visits each of the active treatment hospitals and the auxiliary hospitals in Medicine Hat, Lethbridge, Grande Prairie and Red Deer once a week to arrange for continuing care of patients when they are discharged from hospital.

In Calgary and Edmonton branches a more formal referral program has been developed. A Victorian Order nurse is assigned to the Calgary General Hospital three hours each day, five days a week. The nurse makes rounds on the various wards each day and is available for consultation and conference with physicians and hospital personnel. Office space with a telephone is provided by the hospital. The hospital pays the Calgary branch the cost of the service calculated on an hourly rate. Similarly, programs have been established in the Holy Cross Hospital, Calgary and the University Hospital in Edmonton. Programs of lesser time are also functioning at the Rockyview Hospital and the Foothills Hospital in Calgary.

Other programs once established in Edmonton have been discontinued: Royal Alexandra Hospital in 1965; Misericordia in 1967; and the Glenrose in 1967. The discontinuation was due to a number of factors. An operating deficit in one hospital and the development of social service departments in the other two hospitals were given as reasons. However, the number of patients referred by these hospitals for nursing care at home was relatively small. The cost of the programs could not be justified in view of their apparent ineffectiveness. As stated earlier, more than one-half of all patients cared for by the Victorian Order had been hospitalized, yet only about 29% of these patients had been referred to the Order by hospitals.

One of the primary aims of a hospital referral plan is improved patient care. The Victorian Order liaison nurse works with hospital staff to ensure that the patient feels secure about leaving the shelter of the hospital and that he has available to him necessary community resources when he returns home. The Victorian Order nurse visits the patient, carries out the doctor's orders for nursing care, teaches the family how to care for the patient in the absence of the nurse and gives necessary health instruction for improved health practices. The doctor receives periodic reports on the patient's progress. If re-admission to hospital is necessary the hospital staff receive a report on the home care given by the Victorian Order nurse.

Other services specific to certain communities include: an occupational health nursing service in Medicine Hat for a large industry; a similar service but on a smaller scale for an industrial firm in Lethbridge; classes for expectant mothers conducted at four of the branches in 1967; four branches provided field experience for public health nursing students from the Universities of Alberta and Saskatchewan; and periods of observation were provided by the Order at four branches for students from eight hospital schools of nursing.

Personnel

A total of 32 nurses were employed in the branches in 1967; 3 in Medicine Hat, 2 in Lethbridge, 13 in Calgary, 14 in Edmonton, and 1 in Grande Prairie. Twenty-eight of these nurses have preparation in public health nursing. The district director in the Edmonton branch has additional preparation in public health nursing administration and supervision and psychiatric nursing. The district director in Calgary has additional preparation in teaching and supervision, and one staff nurse has post-graduate preparation in psychiatric nursing.

Relief and substitute nurses are employed in all branches. Each branch maintains sufficient staff to serve the community at all times.

A regional director employed by the national office works in Alberta, providing liaison between the provincial association and the national organization supervising the nurses and acting as consultant to members of boards and district directors.

Mental Health Services

Possible Developments

The Victorian Order of Nurses, in all aspects of its program endeavors to incorporate emotional support and recognition and reporting of psychological problems. Today psychiatric nursing and rehabilitation nursing are parts of the basic education for nurses. The nurse must have an understanding of normal growth and development and deviations from the normal with respect to both physical and mental aspects of the human being. Understanding and helping the family to understand the total physical, mental and emotional needs of the patient is a prime responsibility of the nurse.

In recent years there has been a growing emphasis on the care of mentally ill patients from hospital still requiring nursing supervision. People concerned with health programs are beginning to ask, "What does this patient need?" "Where will he make the best recovery?" If co-ordinated home care programs were available as an alternative to hospital care, a more efficient use of available facilities in the community could result. All services required by patients could be coordinated through a central administration. Duplication of effort could be eliminated and,

of equal importance, there would be fewer gaps in essential attention for long-term patients.

In a psychiatric home care program the nurse may supply supportive therapy to patient and family; she may act in a supervisory capacity in the administration of drugs; she may give nursing care to the patient. The program includes rehabilitation, community referrals, reporting, conferencing. This kind of guidance and support has made it possible for many patients to be cared for by their families in their own homes, and discharge has been accepted more readily by families. The Victorian Order is participating in a psychiatric home care program in Saskatoon and a number of branches in other parts of Canada provide nursing supervision to psychiatric patients referred by other agencies and/or hospitals.

In 1966 the Calgary branch participated in the development of a follow-up program in the home, for patients discharged from the psychiatric department of the Foothills Hospital. Discussions were held with the director of psychiatry regarding the development of follow-up service for selected patients discharged from the hospital. It was felt by the director that home nursing service should be provided by the nursing staff of the psychiatric department. The overall objective of the program, as described by the director, was to demonstrate that patients treated in hospital could be discharged and cared for adequately, providing the family physician and hospital nurse carried out the continued care at home. The involvement of the family physician in the treatment and care of the patient in hospital and at home under the direction of a consultant psychiatrist was basic to the hospital psychiatric service.

A senior staff member of the Victorian Order was already employed in the regular referral program of the hospital. The Order was asked to assist through regular consultation with administrative and supervisory staff of the psychiatric department in relation to: preparation of records; determining appropriate community agencies for referral of patients; and helping the visiting psychiatric nurse to plan for a home visit and to be available if necessary for discussion following the visit.

In this program the emphasis was on the continued therapeutic care of the patient after discharge from hospital. While it was recognized that the program was planned to assist general practitioners in the community with the management of their psychiatric patients at home, the Order believes that many more mentally ill patients could be followed at home by public health nurses already working in the community. The combined personnel of the health departments, health units and Victorian Order branches offer resources of personnel and service that should be utilized more effectively than is being done at the present time.

It was interesting to note that psychiatric nurses from the hospital unit, making visits with the Victorian Order of Nurses in the community, remarked that many aspects for the promotion of good mental health were observed in almost every visit, and that, obviously, prevention in this area was an essential part of the regular Victorian Order program.

Coordination of V.O.N. Services with Other Health and Welfare Services

Victorian Order programs are developed in cooperation with local health departments. Programs are planned to prevent duplication and overlapping of services. Referral procedures have been developed for the exchange of information between health departments and the branches. The need for integrated planning of community mental health services has been recognized and the following programs could be used more effectively.

Referral Programs

Because the primary purpose of the Order is to provide nursing service to patients ill at home a close liaison with psychiatric units and mental hospitals is essential for effective service. There is a definite need for pre-discharge planning if a patient is to receive the benefit of continuing care.

The provincial mental hospitals offer opportunities for closer liaison with nursing services in the province. Patients discharged from the mental hospitals and returning to their homes would benefit from supportive care and nursing supervision. The Victorian Order is participating in follow-up programs for mentally ill patients elsewhere in Canada and feel similar programs could be developed in Alberta.

As yet (1967) there is no regular system of follow-up for patients from Oliver or Ponoka, although there has been some interest shown in using the nursing service provided by the Victorian Order of Nurses in the Red Deer branch.

Coordinated Homes Care Programs

For many psychiatric patients, visiting nursing service under the direction of the patient's psychiatrist or family physician provides all the care that is necessary. Others require a range of services, medical, nursing, social work, housekeeping, nutrition, occupational therapy, etc. for adequate care and rehabilitation. It is the provision of a range of services for the patient at home which characterizes coordinated home care. The coordination of these services, so that the patient receives each of them in the amount, in the best place and for the time required, is not available in Alberta at the present time.

In many communities in Alberta the components of coordinated home care are generally available. What appears to be required is the leadership to coordinate the existing resources and the assurance of financial support. From experience gained in programs in the other provinces, the Victorian Order is prepared to participate in the development of coordinated psychiatric home care plans in Alberta.

Financing Service

Victorian Order service is financed through three main sources; nursing fees from patients or payments on behalf of patients through government and contractual arrangements; municipal grants and community appeals, either through community chests or local fund raising activities. The Victorian Order is still dependent to a major extent on voluntary giving to maintain its service.

The fee for a visit is based on the cost per visit. It is computed on a visit rather than a time basis, the visit being accepted as the chief unit of service in visiting nursing associations. The average cost per visit provides a basis for calculating charges for services rendered at cost, and it also provides the basis on which branch boards determine the maximum fee to be charged.

The cost of Victorian Order service in Alberta in 1967 varied from \$3.17 to \$4.32 with an average cost of \$3.78 per visit.

In Alberta there is a growing resistance on the part of patients and families to pay the cost of nursing service. Strong opinion has been expressed that visiting nursing service is an essential public service and should be financed through existing health legislation. A number of patients are reluctant to pay for visiting nursing service when it is learned that the Alberta Health Plan does not make provision for payment for these services.

Summary and Conclusions

The Victorian Order of Nurses in Alberta has branches in 6 communities with a staff of 33 nurses. Most nurses have had basic preparation in psychiatric nursing, and inservice education programs are arranged to meet needs of staff in relation to current programs, using consultant resources in the community. The Order will provide nursing services to mentally ill patients in the present branches and will extend boundaries and service to other communities to meet needs.

If payment for service to the mentally ill patient were included in the Alberta Health Plan more patients would be willing to receive care at home when this is feasible. Through the regular Victorian Order program and through participation in coordinated home care programs such as are carried out in other provinces, it has been demonstrated that a number of psychiatric patients can be successfully rehabilitated at home.

The Victorian Order accepts a responsibility to assist with the development of improved mental health services in Alberta. As a voluntary agency it has repeatedly demonstrated its flexibility in providing a

variety of services in communities across Canada. In cooperation with health and welfare organizations, the Victorian Order is willing to participate in the planning or implementation of programs which will bring about better service for patients with mental disorders who can be treated at home. The basic requirements for such participation would be demonstrated need and financial support.

APPENDIX I

STATISTICAL ANALYSIS OF SERVICE

1967

TOTAL PATIENTS	7,044
<u>Maternity and Newborn</u>	4,305-61%
Prenatal	43
Postnatal	2,086
Newborn	2,176
<u>Medical and Surgical</u>	2,739-39%
Nursing care	2,640
Health supervision	99
<u>TOTAL VISITS</u>	62,062
<u>Maternity and Newborn</u>	12,812-21%
Prenatal	156
Postnatal	3,832
Newborn	8,824
<u>Medical and Surgical</u>	48,561-78%
Nursing care	47,634-77%
Health supervision	927- 1%
Other (P.N.S. & O.B.P.)	689- 1%
<u>PAY STATUS OF VISITS</u>	
Full	11%
Part	33%
Free - No Charge	38%
Contract - Government - Insurance	18%

OTHER NURSING VIEWS

Three other submissions will be summarized in this section. One was prepared by an administrator Mr. R. Coombs, R.N., R.P.N., of Foothills Hospital for consideration by the Study Group on Relative Roles of Professional Personnel. The second and third originated at the Alberta Hospital, Ponoka. All three provided support for concepts enunciated in the briefs which appeared earlier in this Chapter. In particular, the following arguments advanced by the two provincial nurses' associations were reinforced.

1. That there must be provision for the continuing education of graduate nurses. (The availability of training grants and leaves of absence for professional training were seen as necessary to make professional upgrading a reality.)
2. That nursing education should take place in an educational environment with the student free from service requirements.
3. That case loads, classed as "impossible," must be reduced if treatment programs are to become effective.
4. That nurses must be freed of routine, domestic and porter's duties if they are to participate in treatment programs to a useful extent. (Mr. Coombs reported a study done in a New York hospital which indicated that about one-quarter of 92 nursing functions required a nurse; the remaining three-quarters could have been performed by aides. The qualifications of staff were reversed: only one-quarter were aides. He concluded that only "lip service" is given to the need for better use of nurses by both administrators and nurses. He called for study to identify essential and non-essential nursing functions and for "a genuine willingness on the part of nurses to give up those duties that can adequately be performed by others.")

The hospital nurses' groups differed from the V.O.N. regarding the organization of follow-up services for persons released from mental hospitals and psychiatric units. The hospital nurses proposed that after-care services should be operated directly out of hospital, employing hospital-based nurses. They contended that positions for home-care nurses should be created in out-patient clinics of hospitals and in the Provincial Guidance Clinics. The V.O.N. offered to provide that service as an extension of their present home-care programs, subject to their coverage under the Alberta Health Plan. Briefs from health units published in Chapter 3 indicated that Public Health Nurses from the health units are also available for follow-up services. There is a big job to do in this field and more nurses are required. There are many willing hands, however, whose services are not being used fully. A first step toward the

provision of adequate follow-up services surely would be to enlist the help of all available resources and put them to work in a coordinated manner.

Other points raised in the briefs will be presented now in summary form.

Nursing Administration and Supervisory Staff Alberta Hospital, Ponoka

A concentrated recruitment program should be carried out to attract adequately trained staff. Improved personnel policies should be introduced to increase the status, prestige, and financial rewards of those caring for the mentally ill. These recommendations apply not only to the nursing profession, but to all professional staff, including occupational therapists, social workers and psychologists.

The Departments of Nursing in mental hospitals should be delegated authority commensurate with their responsibility. They should also be consulted in the planning, budgeting, etc. of mental health services.

Community psychiatric services should be developed on a regional basis.

Adequate preventative and follow-up centers should be established. Day and night care treatment centers, half-way houses and foster homes are also needed widely and urgently.

General hospitals should provide treatment for emotionally disturbed people. Back-up facilities should be provided for persons whose treatment is beyond the scope of the general hospital.

School of Nursing, Alberta Hospital Ponoka

Administration

Mental health services should be established and coordinated with all other health services on a regional basis. An institution such as Alberta Hospital, Ponoka should be governed through a board of directors which would have control of the monies necessary to carry out the services they provide. Such institutions should be headed by qualified business administrators, while clinical treatment programs would remain under the direction of medical and nursing personnel.

Organization

The present Director of Nursing position should be reorganized into two positions, a Director of Nursing Service and a Director of Nursing Education. The classification and pay scale of nursing instructors should be set up according to years of related academic and clinical

preparation. A differential pay scale for academic qualification (e.g., degree or diploma) should be instituted for nursing service positions.

All nursing education should be under the direction of the Department of Education and should be the responsibility of nursing educators (not other professionals, e.g., medical doctors). Monies now used for service wages to psychiatric and basic students should be put into funds for bursaries, loans, and grants. This change would emphasize the educational and not the service role of the student nurse.

None of the present nursing education programs really fulfills their original purpose. We see the long-range goal as the preparation of all nurses as "generalists" at the undergraduate level in diploma or degree programs. (The CNA states, "That two categories of nursing practitioners should be prepared within the general educational system ... the professional nurse ... in a four year ... university program ... the technical nurse in a two year program under educational auspices.") Specialization should begin after graduation from an undergraduate program in nursing. The present four year combined general and psychiatric nursing program should be shortened to three years. No attempt should be made at the hospital level to provide education in "advanced psychiatric nursing." Except for clinical experience, this education should be provided by a university. Thus the present post basic course at AHP should be discontinued and university courses should take its place. Unless this is done, the need for psychiatric nurses will increase, not decrease, and there will be an even greater lack of qualified registered nurses to guide the services offered by increasing numbers of auxiliary and non-professional groups involved in health care.

Physical Facilities

Present educational facilities require immediate improvement and expansion; e.g., a separate building for the School of Nursing, a centralized library staffed with a full-time librarian, adequate office space, change rooms, etc. for staff and students.

Recruitment

Continuous advertising should be carried out for qualified teaching and nursing service staff. The criteria for selection of the provincial recruitment officer should be examined. She should be chosen in consultation with representatives from the AARN and PNAA.

Organization in AHP

AHP should be decentralized into semi-autonomous units. Each unit would have a variety of patients and the transferring of patients from ward to ward would cease. Each unit would also have a team of professionals working within the unit. Patient care would thus be improved since staff would become involved and committed in their relationships with patients and with each other. One mixed staff complement with integration of male and female staff, both in terms of control and ward assignment, should be provided. For many years male staff have worked with male patients and female staff have worked with female patients. This division results in considerable difficulty in communication between the two staff groups due to mutual feelings of antagonism centered on status, male and female roles, responsibility and competence. These problems are prolonged and encouraged by policies at the Department of Health level. Provision is made for 259 female positions (approximately 300 female patients at AHP) and 190 male positions (about 650 male patients at AHP). Thus an imbalance in the amount of care provided for male patients has existed for many years.

Many inadequacies in professional staffing exist in other departments in the Hospital:

1. A qualified occupational therapist should be immediately sought and employed to head the OT department. Adequate facilities should be provided for this department.
2. An acute shortage of clinical psychologists exists (the workload in the psychology department at AHP has been handled in an outstanding manner by one permanent psychologist for most of the past decade).
3. The department of social work is sorely lacking in personnel and lacks a qualified social worker to head the department.

Adequate facilities and qualified staff should be provided without delay to treat patients with addiction problems, geriatric cases, children and teenagers with emotional problems (e.g., qualified school teachers to teach these children).

Research

Money should be provided for adequately prepared personnel to do research in the area of psychiatric care.

Comment

Most of the briefs revealed a desire for clarification of the role of the nurse in mental health services. Mr. Coombs stated, "Each discipline,

which interacts with nursing, sees the nurse in a different light and each nurse interviewed saw herself somewhat differently than the nurse interviewed before her." The nursing administration and supervisory staff at Alberta Hospital, Ponoka, proposed that "research should be conducted concerning the role of the nurse in the psychiatric setting, how the nurse should best be educated, what the nurse's role is with respect to other related professions."

It was noted by Mr. Coombs that nurses believe they are inadequately prepared to function as full members of the mental health team. However, he also commented that it is not possible to prepare the nurse adequately until her role is more clearly defined.

I would note that there are several substantial points of general agreement and they could form the base for action to help clarify the role of the nurse in mental health services, delineate her essential preparation and ensure that she is employed appropriately.

1. The nurse is needed in mental health services as a vital agent in treatment programs.
2. She must not be assigned to housekeeping or routine chores which can be performed by less qualified non-professional people.
3. She must be regarded as the equal of other professionals in treatment programs and: participate in the development of treatment schedules in individual cases; and be granted authority to engage in therapy in hospitals and in the community, referring to other professionals those persons whom she judges should be referred.
4. She is the only agent-of-treatment, who is in regular contact with disturbed persons, so, above all, she must have the following abilities:
 - a. The ability to detect behavioral change which requires a change in treatment.
 - b. The ability to identify the nature of the change and what kind of treatment is required.
 - c. The ability to engage in therapy, on an individual or group basis, and to provide the required treatment.
 - d. The ability to communicate to other professionals, and to administrators, patient problems and proposed solutions which lie outside her province.
 - e. The ability to teach persons about a wide range of health matters.

5. She is a logical agent to provide follow-up, rehabilitative, adjustive care when persons are released from clinics or hospitals and she should be so prepared that she can decide when to consult other professionals.

If the above concepts are supported generally, many more nurses are needed in mental health services in hospitals, in out-patient departments of hospitals, as professional partners of family physicians, (and this is critical) as public health nurses in health units and in voluntary societies and orders.

The nurses' preparation for the role, described above, should include:

- a. Basic education and training now provided for diploma (R.N.) nurses.
- b. Additional education, not included in (a), now constituting baccalaureate programs at universities, to establish a base for subsequent development as well-educated, professional people.
- c. Training, which is specific to psychiatric nursing.
- d. Postgraduate education for many and continuing education for all nurses.

CHAPTER 6

PSYCHIATRISTS

Psychiatrists contributed substantially to the Alberta Mental Health Study. Eleven study groups were formed to examine such subjects as manpower for mental health, emotionally disturbed children, addiction, northern mental health problems and the relative roles of professional personnel in mental health. Psychiatrists were chairmen of all five of the groups just named. In addition, they served on four of the study groups as members.

Four of the eight outside consultants to the Study were psychiatrists; one of the eight special projects of the Study was directed by a psychiatrist; and three psychiatrists participated as commission members at public hearings held at five locations in the Province.

In addition, psychiatrists from the Public Service, in particular the late Dr. Ralph E. Schrag, then Director of the Division of Mental Health, assisted in the design and cooperated in the conduct of the Study.

The profession of psychiatry thus had a significant degree of input of ideas and information, as indicated above. Their contributions did not end there, however. Dr. L. J. Kotkas, who is in private practice in Lethbridge, prepared a paper on the role of the psychiatrist when he served as a member of the Study Group on Relative Roles of Professional Personnel. He also wrote a private submission. The Study received a submission from the Calgary Psychiatric Society. Two individual psychiatrists, Dr. J. L. Paterson, then Superintendent of the Alberta Hospital, Edmonton, and Dr. J. B. Van Stolk, who had worked as a travelling psychiatrist in Northern Alberta, also submitted their views to assist with the Study. The submissions just named will be summarized in the paragraphs to follow.

Dr. L. J. Kotkas

A major problem in the delivery of mental health services, according to Dr. Kotkas, is the current shortage of psychiatrists, a problem which will exist for many years. He reported on an estimate that, "if all medical graduates of Canada and the United States specialized in psychiatry successfully, it would take until the end of the century to meet minimal current needs in those countries." Although he argued that production of psychiatrists obviously should be increased, other solutions to the problem of their scarcity were demanded now and would be required indefinitely. These solutions included:

1. Making greater and more effective use of the family physician in the delivery of the required services. Dr. Kotkas noted that the family physician "is becoming a major provider" of such services and is the first person to whom persons in trouble are likely to turn.

2. Employing the psychiatrist to a large extent as a consultant to the family physician and as his "coworker" in the mental health field. In this way the special skills and knowledge of the psychiatrist could be made available to a much larger number of troubled persons and better use of the psychiatrist would be possible.
3. Employing other physicians, but not psychiatrists, to attend to the "physical health needs of the mentally ill," thus enabling the psychiatrist to make the best use of his time.
4. Employing more non-medical professionals, specifically psychologists, social workers and psychiatric nurses, on mental health duties for which they have been specially trained.
5. Fostering a closer relationship between psychiatry and the rest of medicine by enlisting the support of the latter and by the integration of psychiatric services into medical services "geographically and administratively." The main focus of psychiatric care, like other medical care, in his view, should be the general hospital, not the large mental institutions often located "in remote country areas."
6. Developing a trend away from "civil service" practice of psychiatry and toward private practice, community or municipal services, with economic support on the same basis as the rest of medicine. Exceptions would be required in isolated areas where travelling clinics would still be required under governmental auspices.

Dr. Kotkas noted possible dangers in centering developments of the Province's mental health services in the Public Service. Because "training and qualification requirements can be waived by the Government," he said, "there are few psychiatrists in government service who would be recognized as duly qualified psychiatrists in the legal sense." However, he acknowledged that there is a place in the system for partially qualified people, who are in training, or in very rare cases where fully qualified psychiatrists simply can not be obtained. A second, related danger is that government institutions do not limit the number of patients for whom each qualified psychiatrist is responsible.

He observed that good working conditions (including in-service training and reasonable work loads) plus the presence of adequately qualified professional staff, are factors which will attract other qualified persons to mental health services. He urged that steps should be taken to train, attract and keep qualified psychiatrists in Alberta because their numbers are not sufficient to provide a base for progressive developments in mental health.

On the subject of services he proposed: larger, more autonomous guidance clinics and community health clinics; specialized institutions for cases unsuitable for general hospitals, such as forensic problems and certain children and adolescents; an integrated network of preventive and after care services; and psychiatric units for all larger general hospitals.

Finally, he urged that the Government provide for wider participation in the planning of mental health services and an end to "the near monopoly of planning" which had been "maintained by the Department of Public Health."

Dr. J. B. Van Stolk

Dr. Van Stolk proposed a formal regional organization of mental health services, using the existing public health boundaries. Like Dr. Kotkas he strongly favors private practice by psychiatrists and a fee-for-service arrangement for all. He supports the concept of providing hospital services for mentally disturbed persons, except for forensic problems, at general hospitals and proposes that fifteen per cent of hospital beds be reserved for psychiatric patients in each. In opposition to current trends, however, he does not consider it necessary to set up psychiatric wards.

Dr. Van Stolk would establish a provincial mental health commission with wide representation and mainly autonomous status, similar to boards of governors of universities, to guide local hospital and mental health boards. It will be apparent that he sees mental health programs as community responsibilities. Indeed, in his plan there would be no provincial mental health service and no government psychiatrists. The Government would decide how much money could be spent on mental health but the authority to decide how it is spent would reside at community level. He would employ lotteries to obtain money to improve facilities and services and to launch a widespread research program in mental health.

Dr. J. G. Paterson

Dr. Paterson's submission dealt entirely with day care centers. He summarized their advantages over conventional hospital care as follows.

Patients under this system would come to the hospital during the day and would return home in the evening, remaining in contact with the family and his social group. Patients are treated in the hospital from nine to five in the afternoon.

The corollary of the day hospital is the night hospital. Patients, who are well enough to work but who are unable to adapt to a traumatic home situation, come to the hospital after work, receive treatment in the evening and sleep there.

A common sequence of events is for a patient to start treatment in the day hospital, take on a job in the community when he has improved, continue treatment in the night hospital while at work, and then continue at work while living, with further improvement, in a moderately sheltered residence.

Calgary Psychiatric Society

There should be a decentralization of authority to local boards of control which are directly responsible to the Minister of Health. These boards should have local autonomy.

Local coordinating committees should be organized with psychiatric consultants available, when indicated, on an advisory basis. There should be a team of consultants composed of experts in the fields of psychiatry, psychology and psychiatric social work. This team should be responsible for providing leadership and supervision for the development and operation of local programs.

An epidemiologist should be made available by the Government to work with the consultant team to assist in determining problems of different areas as well as the nature of different types of illness in the different areas.

The focus should be on personnel versus buildings, on psychiatric wards within general hospitals versus large mental hospitals, and on integration of psychiatry with other fields of medicine. Emphasis should be placed on the philosophy of treatment.

Finances for treatment should come through the various insurance sources on a plan whereby services obtained from, for example, Guidance Clinics, would be paid for on this basis.

A greater effort should be made to obtain the most highly qualified personnel possible. Incentives in the form of opportunities for teaching positions as well as clinical work should be provided.

Guidance Clinics, psychiatric wards and mental hospitals should be accredited. Salaries should be on a basis of training and experience rather than seniority. There should be an inclusion of ancillary groups and a time fee-for-services basis with standards set by the Government and the supervisory personnel of the specific groups.

There is a great need for a clear formulation of provincial policy in mental health programs.

Within the Province there should be research of a pure nature at university level and an opportunity for clinical research in the clinical fields. Grants on an adequate level should be supplied for this research. Present health and welfare grants for research should be designated speci-

fically for research, rather than being allowed to be diverted to the development of further treatment facilities.

Adequate facilities for the treatment of disturbed children and adolescents should be provided. Possibly a board of accreditation for children's and adolescents' treatment centers should be developed so that these units could be financed in a way similar to psychiatric units in general hospitals. Planning of these units should be worked out in conjunction with the local people who will be using these facilities. The emphasis should be on small cottage type units with adequate facilities and staff.

Continuing psychiatric consultation should be made available to the juvenile and family courts, especially with a view to prevention and rehabilitation.

A program of standardized training of child care workers should be established.

It would be helpful to have assessment teams available in diagnostic centers where children with intellectual and neurological handicaps could be referred for thorough physical, neurological and psychological assessment.

There should be decentralization of retarded children's training so that the schools are in the geographic area that they serve. The purpose is to achieve the most efficient rehabilitation of the child back into the community from which he comes. Special classes, sheltered workshops, etc. should be further developed. Research in the area of retardation should be carried out.

Psychiatric clinics should be provided at the universities. A full-time psychiatrist should be directing the counselling staffs that could consist of psychologists and social workers. New students applying to the university should be scrutinized from a psychiatric point of view. Research should be carried out in this area also.

Well trained counsellors, both in the vocational and mental health field, should be provided in schools. Psychiatric consultants should be provided. Visiting teachers should be made available to rural schools.

Due to physical distances, especially in Northern Alberta, there is more need for local treatment facilities to be available in smaller centers. Psychiatrists should have the incentives to locate in such centers. Travelling clinics are a second choice. Guidance clinics should be staffed by private practitioners who are allowed the privilege of part-time private practice.

Adequate treatment facilities should be provided for those in legal difficulty so they could be treated in a hospital confinement type of facility rather than a prison hospital type. Emphasis should be on treatment and not punishment. These facilities should be located near a teaching facility or university setting rather than a prison setting. Adequate research in this area should be carried out.

A drug should be made available on a medically-controlled basis to people who are addicted in order to eliminate the problem of the pusher. Adequate treatment and research facilities should be provided in this area. Possibly legislation could be provided to detain them in the treatment center until they are adequately treated. Programming and treatment aspects of a forensic psychiatric service should be carried out by the Department of Health, while the overall administration should be delegated to the Attorney General's Department. These two departments must cooperate closely.

CHAPTER 7

SOCIAL WORKERS

1. Survey of Mental Health Services in Alberta¹ Alberta Association of Social Workers

Introduction

The term "Social Worker" in this brief refers to those persons who qualify for membership in the Association. There are approximately 180 members in the Provincial Association including provisional and non-practising members. Membership requirements are specified in the Constitution of the Association as follows.

1. All residents of the Province of Alberta who are members of the Canadian Association of Social Workers and who have paid the annual fees set by the Board of Directors shall be eligible for full membership in the Association.
2. All residents of the Province of Alberta who:
 - a. have graduated from an accredited university or the equivalent thereof as may be determined by the Board of Directors; and
 - b. are currently employed in social work positions; and
 - c. have given a definite undertaking in writing to the Association to complete professional social work education to a level that will qualify them for membership in the Canadian Association of Social Workers, this education to be undertaken within five calendar years from admission to provisional membership; and
 - d. have paid the annual fee set by the Board of Directors, may be granted provisional membership in the Association.

This brief attempts merely to give a capsule summary of general opinions, which are shared by those from every area of social work. Other opinions and particular concerns will be expressed in separate briefs by other social workers.

¹ This is a shortened version of the Association's brief. A committee prepared the original under the chairmanship of Mr. Walter G. Coombs. Other members were: Mrs. Lynne Mansfield, Mr. W. McKenzie, Miss Audrey L. Peach, Miss Margaret J. Porter, and Miss Barbara Toni.

According to the Economic Council of Canada, by 1975, eighty per cent of the population will be living in urban areas. Decisions regarding the kind, quantity, quality, and organization of health and social services must take that fact into account. Urban life is highly inter-dependent. To a degree to which he is largely unaware, the urban citizen depends upon a wide range of services administered by some government, available on demand as required. Services to maintain law and order and to prevent epidemics, seem to be the least questioned as essential to urban life. It is when we look at the more intimate aspects of life, that the provision of services becomes confused by ideas which are invalid in today's urbanized and highly technical society. An example is the prevalent concept that an individual is solely responsible for his own destiny, and that, if he fails to overcome obstacles placed in his way by society and requires help in the form of mental health or social services, he is irresponsible, unworthy, and flawed. This concept is in direct opposition to the social work philosophy, that all the benefits of civilization should be available to every member of that civilization. However, if people are to receive the services to which they are entitled, the services must be well organized and administered.

This Association is concerned about the kind and quality of social services available in the Province of Alberta. The purpose of this brief is to outline the functions the social worker can perform, and the staffing which is essential, if the services are to be effective.

Role of the Social Worker in Mental Health Services

In 1961 it was estimated that ten to fifteen thousand persons with the degree of Master of Social Work were needed in the field of social welfare. At that time, schools in the United States and Canada graduated only two thousand annually. The gap is still as great, if not greater. It is, therefore, of paramount importance that skilled and experienced personnel should occupy positions, where the fullest use can be made of their professional skills. It is emphasized that there is no substitute for experience in direct service to persons in need.

Treatment

The traditional role of the social worker in the mental health field has been one of direct service to clients and their families, as part of the clinical team. In addition to mental health services, social workers have functioned in a variety of community settings, as indicated in the following list.

1. Community Social Services:
 - a. Educational (school counselling, family life education, adult education);
 - b. Preventive (family counselling, pastoral counselling);

- c. Supportive (day care, day nurseries, homemaker service, recreation)
 - d. Casualty Services (crisis services, juvenile and family court services);
 - e. Rehabilitative Services (sheltered workshops, rehabilitation units and societies, child welfare, public welfare, etc.)
2. Community Mental Health Services:
- a. Canadian Mental Health Association
 - b. Mental Health Clinics
 - c. Home Treatment (e.g. after-care)
 - d. Psychiatric Units and Hospitals

The above outline is a composite of services which should exist to provide continuous care from assessment through treatment to after-care and rehabilitation. Many of the services listed are already in existence, but there are obvious gaps, especially in the supportive and rehabilitative fields. More important is the lack of an integrated system of mental health services with the result that existing services are not properly utilized, and people may be lost while passing from one phase of treatment to another. We recommend that coordination of mental health services, on a regional basis, be given high priority to ensure maximum utilization.

Policy Making and Administration

At the Federal level of government, social workers are involved in the formulation of policy. In Alberta, similar advantage should be taken of their knowledge and experience. We recommend that suitably qualified social workers be employed at policy making and administrative levels of government where services to people are involved.

Prevention

Social workers in the mental health field should also be used as consultants to professional groups, agencies, and the community. Increasing the understanding of mental illness extends the sources of help and the influence of clinics. Recognition of symptoms at an early stage makes for more effective treatment. Greater sensitivity to individual and collective trouble spots in the community could help prevent serious mental disturbances.

Research

A vast amount of information about the family and social concomitants of mental illness is accumulated by social workers. This information should be compiled and used as the basis for further studies, or as a guide for improved services. We recommend that social workers trained in the techniques of research be employed, along with researchers in other fields, to plan and develop total research programs, not merely isolated projects.

We commend the Canadian Mental Health Association for the extensive educative work which it has done over the years in the field of mental health, but more is needed. We recommend that provision be made in mental health services for this kind of dissemination of information to the public, about existing mental health programs in the Province, and current and future developments.

Staffing Social Work Services

Standards

The Canadian Mental Health Association in 1962 published the results and recommendations of a five year study of psychiatric treatment services in Canada. Among the recommendations were the following:

That a variety of mental health services be provided in every large community to ensure local, immediate, and active treatment of the mentally ill.

That every general hospital provide psychiatric services, and that in the larger hospitals (over 200 beds), psychiatric units or sections be established.

In the community, social agencies are involved in early case finding, referral, after-care, and rehabilitation. Qualified social workers should be hired to run the programs in these agencies. 1

Standards for hospitals and clinics, published by the American Psychiatric Association, and a similar manual published by the Canadian Hospital Association, specify social services as an essential unit wherever psychiatric services are provided.

Social services should be staffed with qualified personnel, i.e., graduates of recognized schools of social work. To ensure that positions are filled by suitable candidates, clear job descriptions and selection requirements should be available.

¹ Canadian Mental Health Association. High Road to Mental Health.
Toronto, September, 1962, 9.

Personnel Practices

Social workers should be accorded the same treatment as professionals in other fields.

We recommend that personnel policies and practices of the Government recognize the demands made on professionals. They are prepared not only to treat, but to educate, and to do research. Time needs to be allotted for each function.

The quality of service is determined by the quality of staff. Services which use the skills of well qualified staff appropriately, offer them challenge and stimulation and recognize and respect them as professionals will attract and retain high quality personnel. We recommend sufficient flexibility in personnel policies and practices to provide for personal development, e.g., leaves of absence for study should be available.

Salaries for social workers in mental health in Alberta are generally lower than those of other helping professions with equivalent preparation. Salaries must be at the very least competitive to attract and hold suitable persons from other places. The present scale may attract workers at the Bachelor of Arts level, but at the Master of Social Work level it is far less attractive, and still less attractive to the more experienced social worker. The Association has information on salary scales and is prepared to advise the Government and other employers.

We also recommend that time and money be made available for participation by social workers in seminars and conferences.

Recruitment and Education

There is a need for more aggressive recruitment specifically for the mental health field. Well qualified personnel are required at the top levels to develop strong programs and effective services. The programs should include education, research and progressive treatment services. National and even international advertising are indicated.

In-Service Training and Staff Development

Such training should be carried out on an interdisciplinary basis using social workers of considerable training and experience. Sufficient time should be allotted to plan and conduct the programs.

It is essential that there be a hand-over for replacements to provide a smooth transition in service. The method of social work supervision and consultation, as it has developed in the profession of social work, is regarded by members of other professions as an effective approach to personnel management. Each social worker should have regular supervision or consultation.

Continuing education for staff should include regular educational conferences.

Grants should be available for continuing education to all who qualify on a competitive basis. Grants of \$4,000 per year were recommended in 1965.¹ We endorse this recommendation; the amounts should be revised periodically.

Recommendations

1. That the establishment and coordination of mental health services on a regional basis be given high priority.
2. That qualified social workers be employed at the policy making and administrative levels of government, where services to people are involved.
3. That social workers in mental health be used as consultants to professional groups, agencies, and the community.
4. That social workers trained in the techniques of research, be employed with researchers in other fields, to plan and develop total research programs.
5. That public relations and public education be an integral part of the mental health services.
6. That only fully qualified social workers be employed in senior positions.
7. That there be recognition in the personnel practices of the Government of the demands made on professionals.
8. That there be flexibility in administrative policy and general personnel practices, to permit leave of absences for study purposes, etc.
9. That the Association act as a consultant to Government regarding salaries for social work positions.
10. That there be national and international advertising for social work positions.
11. That in-service training and staff development be an integral part of mental health services.
12. That grants be made available for continuing education to all who qualify and on a competitive basis.

¹ Canadian Mental Health Association. A Statement of the Royal Commission on Health Services. Toronto, April 1965, 3.

2. Social Workers and Mental Health

G. McLellan¹

There are 3,000 practising social workers in Canada, less than 200 of whom are in Alberta. There are nine schools of social work in Canada, one in Alberta. The experience of the last ten to fifteen years shows the number of graduates yearly is only slightly higher than losses due to such events as deaths, marriages and change of occupation. It does not seem likely that this ratio will increase in the foreseeable future, unless the role of the social worker becomes more attractive.

Our profession is presently struggling with the problems of our role, our image, our future. It is becoming clear that many of our traditional functions could better be undertaken by more specifically trained persons, e.g. welfare workers, social service technicians, child care workers and others. The social worker has become involved in so many services and programs that it is difficult to answer the question, "What is a social worker?" We find ourselves bogged down in talking about the things we do which does not help too much. Our training involves looking at the social sciences and trying to relate these one to another to help us understand the social forces which impinge on the individual, the group and the social order. This background of information is examined in terms of social breakdown, family problems, school problems, delinquency and criminality, divorce, sexual mores, emotional disorders or mental illness, to mention but a few. By the time we graduate we are aware of what these various forces are, what contradictory pressures they exert and the effects they can have on the individual, the group and the social order.

On graduation we move into work situations for which we have too little specific training but by working under supervision we become "specialists." Traditionally social workers have been asked to fill a wide variety of jobs. As changes in social organization and technology occur our jobs change, but always they have to do with the effects of change on people and the problems of adjustment created by such changes.

With the advent of rapid and sweeping changes in social structures and economic and political processes, vast numbers of persons have found their life patterns changed. The result has been disturbing to some and chaotic to others. The old guidelines have gone. Increasing numbers of people are in trouble and seeking help. Without too much considered planning, society has moved to meet the challenge of social change by providing large public services to meet the more obvious needs for social allowances, unemployment insurance, job re-training, technical training, employment services, national pension plan and medical insurance. These provisions

¹ In 1968 Mr. McLellan was President of the Alberta Branch of the Canadian Mental Health Association. This is a slightly modified version of his brief to the Alberta Mental Health Study. W.R.N.B.

have created staffing problems and new employment opportunities in personnel services.

Social workers, along with those from the other helping professions, have moved to meet the more personal needs of the victims of change. The result has been a breaking down of the more traditional roles of each professional group. We find ourselves working with one another doing essentially the same tasks, e.g. group therapists come from every discipline.

Social workers will continue to attempt to define their roles and schools of social work will reflect our changing views. We have recognized the need for technicians, e.g. child care workers, and are now developing undergraduate education. Other professional groups have similar concerns. I believe it is no longer feasible for each discipline to work on its own. If we work together we have a chance of being prepared for the changes still to come. Maybe some of the new service tasks require special personnel and, if they do, we could influence their development and have some control over our own changing roles.

I suggest that the coming into their own of subprofessional groups will change our roles from predominantly direct service to new roles as consultants, advisers, teachers, supervisors, directors and planners.

In the past social workers have sought employment opportunities that tend to meet their own personal preferences, e.g. probation officers, marriage counsellors, youth workers, psychiatric social workers, community organizers, public welfare workers and administrators. We will likely continue this practice since we bring to our search for self expression in work a broad concept of service but not necessarily specific job training. In my opinion a great many of us will seek career opportunities in the mental health field. We will want to be included as members of the team of professionals and with the others we will search for ways to serve as practitioners.

3. The Role of Social Work¹

F. Bach

The role of any professional in the mental health field should be determined, first, by the needs and best interests of the client or patient and, also, by the knowledge and special skills of the professional. In addition, the role is contingent upon the expectations of other professional persons and their confidence in his competence.

The family physician may be an advisor or educator according to the needs of a patient or he may perform as a surgeon in another situation. Similarly, the social worker may be therapist or counsellor to a family in difficulty with their relationships. At some point, he could assume the role of a "change agent," exploring possibilities of modifying influences in society which impinge on the family and produce dysfunction; for example, inadequate public assistance or unfair employment practices. In other situations it may be more appropriate to be educator rather than "change agent," a consultant to a clergyman rather than a therapist. Whatever his role, he is tuned in primarily to the social functioning of the individual, the family, the group, and the community.

Social work educators and leaders of professional associations of social workers have been struggling for years to develop a basic curriculum, membership requirements and standards of practice, which would apply to all practitioners regardless of their settings. This has been a search for our identity as a profession.

The task has been complicated by the diversity of social work positions in a wide range of agencies, governmental departments, institutions and communities. It is often difficult to recognize any common base of knowledge or skills among, for example, the neighborhood worker, the administrator of a public welfare department and the practitioner in a psychiatric clinic.

Nevertheless, considerable progress has been made in North America, and more specifically in Canada, in developing membership organizations and, in several provinces, achieving enactment of legislation regulating social work practice. Schools of social work have generally moved toward a core curriculum but with some specialization in terms of the students' employment plans.

Although the burden of defining each role is clearly on each profession, it is also evident that effective services in an interdisciplinary field, such as mental health, demand a good degree of openness about respective

¹ This paper in longer form was submitted by Mr. Bach in 1968 to the Chairman of the Study Group on the Relative Roles of Professional Personnel in Mental Health. W.R.N.B.

roles. We must strive to develop more opportunities to experiment with a variety of interdependent role assignments and to take a few risks in getting involved with each other. We have in the past "brain washed" our students in our respective professional "clubs" and have given them too few opportunities to interact with students in other professional schools and to test out theory and principles of practice.

We have had too few experiences in providing consultation to each other. Our experiences in this area have been limited primarily to clinical practice and even then this seems to have been a hit-and-miss proposition in many instances. We have been far from imaginative in considering the potential for consultation and team work in the preventive mental health area, for example, in schools and communities.

Most social workers are employed in primary settings, where social work is the major discipline, for example, in family, public welfare, and child welfare agencies. We have defined their roles in relative isolation from other disciplines. Unfortunately in settings, where there have been opportunities for interdisciplinary practice, as in psychiatric clinics, hospitals and general hospitals, roles have too often been established rigidly and experiences in working together have not been generally documented.

Recommendations

1. We should explore ways of providing greater exposure of students in professional schools to each other around a variety of learning experiences geared to developing more meaningful interdisciplinary collaboration.
2. We should develop new models for interdisciplinary collaboration; for example, consultation in private medical practice.
3. We should also look at possible areas for collaboration on research.

CHAPTER 8

PSYCHOLOGISTS

1. A.J.B. Hough, M.A.
Director, Student Counselling Service
University of Alberta

The following statement reflects my views regarding what a psychologist is, what he should be, and what his training should be. I am indebted to Mr. Raymond G. Berry, of Ontario, for information and opinions.

Preamble

The role of the psychologist in mental health is in flux. At one time, those with such interests were trained to the end of a Master's program, and for roles that were primarily concerned with testing and diagnostics. A number went on to doctoral degrees but they usually joined the staffs of universities.

However, a search for identity led to more emphasis on research, the development of empirical knowledge, rather than a grand theory as had been characteristic of the times of Freud and Spearman. On this continent, there is a quite general belief that the basic areas of psychology are those of carefully controlled research, i.e. learning, perception, and motivation. Further, since more people are going on to doctoral degrees, there has been an emulation of the physical and the biological sciences, and emphasis on the Doctor of Philosophy degree as a research degree.

These developments led to changes in the requirements for graduate degrees. The emphasis has been upon a thorough general knowledge of psychology, and, because of the requirement for original research for the doctoral degree, sound preparation in the methods of research, which include the study of basic mathematical theory and methods.

It has followed that the work for the Master's degree must ensure both breadth and depth. It is not possible to include more than a little work in applied fields, if the degree is to be completed in the same time as research degrees in related areas. Since the doctoral degree is a scholarly degree, the emphasis has been on research, irrespective of whether the candidate is interested in a career in research or in an applied career. In some universities, in order to provide appropriate applied training, it has taken from one to three additional years, over the time required of a basic research psychologist, for an applied person to move from the baccalaureate to the doctorate.

This has led to some unhappiness and in both Canada and the United States there have been a number of conferences concerned with identifying roles and recommending training for applied psychologists. In the United States there have been the Boulder, the Miami, the Greyston, and the Boston conferences. In Canada we have had the Opinicon and the Couchiching conferences.

The conferences have given support to the "Boulder model," of an applied psychologist as a scientist and a practitioner. It is argued that the scientific approach, with its raising of questions, will keep the practitioner alert to gaps in existing knowledge, likely to recognize new possibilities as he does his work and able to adequately test the hypotheses he develops. However, the Boulder model envisaged an integration of applied and scientific training, and the aspiring applied person, while exposed to the basic areas of psychology, was to learn his research methodology through apprenticeship with scientists who are actively involved in research in psychopathology, mental deficiency, and so forth. There are some who claim that, with few exceptions, the Boulder Model has not been tried, and that the doctoral degree, for those who plan applied careers, reflects training appropriate to research careers but inadequate training in applied work.

Another factor has contributed to the state of flux. The need for therapists in the mental health field has far exceeded the supply. This has led to psychologists and others becoming involved in treatment. Perhaps, too, the shifting emphasis in training has tended to produce a race of applied psychologists that is not content with the rather routine work of testing and diagnosis. Another influence has been the development of certification and licensing legislation for applied psychologists. While most of this legislation has included "grandfather" clauses, which permit certification for a time of persons with less than the prescribed training, one goal of the legislation is to step up training requirements, with the presumption that the public will be better served. In most states and provinces the doctoral degree is the minimum requirement for certification. A few place the minimum at the Master's level, and Alberta is one such province.

However, there is a continuing need for testing and diagnostic work. In Ontario, for example, there is the provision for the appointment of "psychometrists" and "psychological technicians" to the staffs of mental hospitals, with the understanding that they will operate under the direct supervision of psychologists.

It will become increasingly difficult to obtain the services of psychologists with doctoral degrees who will be content to do testing and diagnostic work. Some will wish to be involved in the more difficult and challenging work of therapy and behavioral change. Others may have research or supervisory interests. Hence, it is important to establish employment criteria within institutions where psychologists are employed, which call

for the appointment of well-trained psychologists, and will give them scope for employment which is consistent with their training and interests. There is a need for psychometrists, or psychological technicians, who should not be called psychologists, and suitable training programs should be developed for them. For some, this training might be offered at universities. For others, it might involve a program at an institute of technology or on-the-job training. These persons should work under the supervision of a psychologist.

The training of applied psychologists should include practicum and interne experience, and, if this training is considered to be a requirement for a graduate degree, supervision of such experience belongs to the university. Joint appointments between teaching departments and the staffs of hospitals and guidance clinics could be encouraged to make such training possible.

Amendments to the "Psychologists Act" should be sought, requiring a doctoral degree for certification. A 'grandfather' clause of five years' duration, should provide a sufficient transitional period.

There is a need to encourage departments of psychology to provide doctoral level training in applied psychology.

Alberta does not have a psychological advisor working with the Department of Health. An advisor could help delineate the duties of psychologists, coordinate their work, establish training plans and advise regarding research.

2. The Psychologists' Association of Alberta

This brief is concerned with psychology applied to the service of mental health in Alberta.

One might have anticipated a strong core of trained, experienced and certified psychologists in the mental health services of Alberta which have a long history. This is not the case. Today there are only six psychologists in the Division of Mental Health, who meet the requirements for certification under the Psychologists Act of Alberta.

The Provincial Government has provided permanent positions for terminal B.A. graduates when this level of qualification is not recognized for certification under provincial law. They should not be assigned to independent, non-supervised positions or to positions carrying the title of "psychologist." The Civil Service has not attracted experienced psychologists to the service of mental health and, with only rare exceptions, the psychological staff of the Division of Mental Health has been unable to make significant contributions to mental health in the Province.

School Psychological Services

Both major cities have well-staffed divisions of special educational services directed by psychologists in the public and separate systems. The Public School system in Calgary, for example, has a service staffed by 9 psychologists, 16 visiting teachers (who are either school psychologists or social workers), 5 reading clinicians, 6 speech pathologists and 3 attendance officers. Psychiatric services are provided by two part-time consultants. Seven have qualifications for certification as psychologist under the Psychologists Act. There are also 158 counsellors in the high schools, fifty of whom have graduate training in educational psychology. Thus, there are many with better psychological qualifications than the B.A. graduates employed in the Guidance Clinics of the Division of Mental Health.

Applied Training in Psychology

The Psychologists Act (1967) requires a Master's degree in psychology, or its equivalent, for certification in Alberta. Graduates can become certified psychologists without a practicum or internship. The psychology departments are not training psychologists in practical skills. In fact, departments and graduates often view current clinical practice as incongruent with science.

There are several possible approaches to applied training of psychologists:

1. Provincial grants might support appointments of clinical professors.
2. Applied training programs might be established in association with the Schools of Medicine, to provide post-graduate training for psychologists and other mental health workers.

Need for Revision of Salary Scales

A review of salary scales for psychologists in 1967 indicated that salaries for psychologists employed by the Division of Mental Health in Alberta were below corresponding levels in other provinces. Salary policy makes it easier for a B.A. graduate to obtain a position in the Division of Mental Health than a psychologist with an M.A. Similarly, a holder of a doctoral degree in psychology cannot afford to work in Alberta unless he holds a teaching appointment at a university or with one of the school boards.

Senior graduates in applied behavioral sciences suffer a considerable gap between their level of salary and the level enjoyed by medical personnel. The concept of the mental health team, in the Division of Mental Health, becomes a wry joke when such a disparity exists. In fact one Ph.D. in clinical psychology with nearly twenty years of experience in the mental health field is paid \$2500 a year less than an uncertified psychiatrist, who is in training at the same clinic. Since the Provincial Government is one of the leading employers of psychological services, its salary levels and professional qualifications should be a model. Moreover, the government agencies should adhere to the qualifications for registered psychologists set out in The Psychologists Act of 1967.

If the Alberta Government would engage the services of only certified psychologists, there would be a considerable improvement in service to the people of the Province. Persons with inadequate professional preparation constitute the majority of government-employed psychologists. Their presence limits the contribution of psychologists to treatment programs in mental health.

Interprofessional Relationships in Mental Health

The traditional diagnostic and treatment approach to problems in mental health in the past 60 years has been a team approach. However, if it is agreed that a team approach is the best, then it must be a team of equals, if it is to work effectively. Much of the dissatisfaction with that approach relates to the tendency of the psychiatrist to be not a member but the head of the team. The well trained psychologist is often unwilling to accept such a position and the well trained social worker often has a similar view. Much of the trouble comes from the acceptance

of the psychologist of a psychometrician's role, contributing to the absurd concept that they are merely medical ancillaries, paramedical workers.

To ensure that psychological services are of high quality, it is essential that the psychologist-member of a team be a certified psychologist. The Government of Alberta disregards its own legislation, the Psychologists Act of 1967, by filling permanent positions with inadequately trained people. Of the 80 certified psychologists on the register in Alberta, only six are employed by the Mental Health Division, a service which is estimated to require at least 24.

Inservice Training and Incentives to Mental Health Personnel

In addition to recruiting mental health staff, psychologists, psychiatric social workers, nurses, and psychiatrists, some recognition other than salary is needed to retain personnel in this demanding field. Government and other agencies are not matching the policy of industry or the universities in providing leaves of absence for study and upgrading. It is difficult even to get time and expenses for a short term professional institute from the present Government. Psychologists working for the Provincial Government should be given adequate time and financial support to maintain their level of professional competence by attending conferences (at least one each year), assuming teaching roles and by conducting research.

Participation of Psychologists in Pre-paid "Medical" Plans

The services of psychologists to the people of Alberta are not paid through the Alberta Health Plan or by private insurance other than an extremely limited coverage by one or two private carriers. The Psychologists Act of 1967 provides for the registration of qualified psychologists. Provisions are made for the disciplining and control of registered psychologists. Since registered psychologists can provide diagnosis and treatment of emotional and behavioral problems, the people of Alberta should have access to such services. This access could be achieved by providing for the participation of psychologists in the Alberta Health Plan, making it possible for groups of medical practitioners to associate with registered psychologists and broaden their scope of mental health activities. Furthermore, the acceptance of registered psychologists in prepaid insurance schemes would permit qualified persons to engage in private practice thus increasing the availability of expert services to the public.

Advisor in Psychology to the Province of Alberta

Most Canadian provinces employ a senior psychologist to act as an advisor to the province with respect to the use of psychologists, the interpretation of their qualifications and levels of competence, and to

conduct liaison with professional associations, negotiation of conditions of employment and salary levels. The appointment of such a person in Alberta would increase the recognition of psychology as a mental health discipline and make the work of the government services more efficient. Such a person could be helpful to the Departments of Health, Welfare, Attorney General, Education, and Human Resources.

Psychological Services and Preventative Mental Health

Prevention of mental ill health depends upon early detection and treatment of behavior disorders. This can best be done in the early years of life, so the school is an obvious site for much diagnostic and remedial work.

The identification of children with behavior or learning problems requires informed teachers and a diagnostic and treatment service. Most urban school systems employ school psychologists but few rural systems are so fortunate. A recent survey of the school superintendents in Southern Alberta revealed that, outside Calgary and Red Deer, there were only two systems employing personnel who could be, even loosely, termed "school psychologists."

There are two necessary conditions for the provision of school psychological services in rural districts: (a) a grouping of neighboring districts to jointly employ such personnel, (b) a more satisfactory provincial grant to subsidize the local school authorities. The question of provincial government subsidization is relevant to the urban systems as well. At present, the Government of Alberta will only subsidize those psychologists who hold teaching certificates and who thus can be classed as teachers. This is clearly an unsatisfactory situation; the Government needs to up-date its policies to recognize the usefulness of psychological services in the educational sphere irrespective of whether the psychologists are trained teachers or not.

Some means of subsidizing rural and small urban centers must be found, so they can attract psychologists more easily than at present. One way would be the provision of bursaries for selected teachers to train as school psychologists.

Recommendations

1. That the role of registered psychologists in mental health be recognized as involving: (a) diagnostic procedures; (b) therapy including behavioral modification, group processes, individual counselling, play therapy, family therapy, social and situational management and other psychotherapy; (c) basic research and the monitoring of psychological procedures and measurements; (d) teaching and supervision in psychological areas.

2. That the Psychologists Act be amended to make the doctoral degree the minimum requirement for certification.
3. That provincial grants be made available to universities for the appointment of professors to develop applied programs.
4. That adjunct appointments to university psychology and educational psychology departments be greatly developed, to encourage qualified practitioners to supervise practical training of graduate students.
5. That the Government of Alberta appoint an Advisor in Psychology to the Province to attend to psychological problems in Departments of the Attorney-General, Health, Welfare, Education, Youth and Human Resources.
6. That the Advisor in Psychology and the Psychologists' Association be included in the employment and salary discussions concerning psychologists and in the development of in-service training policies of the Departments of Health and Welfare.
7. That psychological services in the schools be the responsibility of registered psychologists only.
8. That supervisory positions, in the Division of Mental Health having to do with psychological practice, be occupied by registered psychologists only.
9. That short seminars and institutes be encouraged on a multi-disciplinary basis to facilitate inter-professional relationships in mental health services.
10. That psychology, as an independent profession, be included in the Alberta Health Plan. This would encourage registered psychologists to extend services to the community.

3. Dr. David Gibson, University of Calgary

Dr. Gibson, a psychologist in the Department of Psychology, University of Calgary, was a member of a study group concerned with the roles of professional personnel during the course of the Alberta Mental Health Study, 1968. Other members of the study group were: a psychiatrist, a general practitioner, a social worker and a nurse, plus the chairman, Dr. K. I. Pearce, also a psychiatrist. More will be said later about their conclusions and their important topic. At this stage, however, it is intended to report only regarding the emerging role of the psychologist, and on related organizational and training implications, as perceived by Dr. Gibson and as they complement and support the points of view presented earlier in this Chapter.

He noted in his submission that old roles for applied psychologists exist alongside the new with some psychologists, usually those trained earlier, tending to retain a psychometric orientation and to function as ancillaries to the medical and educational professions. The more recent "scientist-professional" psychologist tends, in Dr. Gibson's view and that of Professor Hough stated earlier, to be interested and to function as a consultant and in other more demanding roles, for example, the treatment role.

The effects of retaining a relatively low standard for certification of psychologists (a Master's degree) in Alberta were seen as particularly damaging to the profession and to its potential contribution. Although the low standard has an apparent advantage in helping to meet short term community needs, he argues that, in the long run, it tends to discourage recruitment of better qualified people outside the Province, "prolongs the view of professional psychology as an ancillary service, encourages continuing use of questionable technology," and provides little incentive to Alberta universities to prepare either psychologists or technologists for employment in the mental health field.

Among the functions of psychological technologists Dr. Gibson would include assessment of "cognitive functioning, psychomotor and psychosensory status, emotional viability and socialization;" and of interests and aptitudes. He would also expect them to participate "in behavioral modification processes, including group processes, individual counselling, play therapies, family therapies, situational manipulation and operant procedures." All of the above functions would come under the overall direction of a certified psychologist.

Additional functions, which would be the responsibility of a certified psychologist, would include: the development and improvement of technologies (i.e. for treatment, behavior change, rehabilitation); monitoring and evaluating the effectiveness of assessment and remediation; in-service training of technicians and technologists and other mental health workers.

Recommendations submitted by Dr. Gibson included:

1. Provision of federal-provincial funds, to "seed" teachers of applied psychology both at universities and in applied settings with university connections.
2. Amending legislation to make Alberta's certification law consistent with other provinces, i.e. to require a doctoral degree.
3. Creation of an advisor in psychology to be a consultant to health and health-related departments in the province.
4. Appointment of a Group IV psychologist, qualified for cross-appointment with universities, at each of the larger health units.
5. Training of psychologists by Faculties of Arts and Science. "The training of hyphenated psychologists by departments of educational psychology, medical schools and business schools is contrary to established goals within the profession insofar as a scientific base is usually not stressed within specialized psychology departments serving a single server profession. An alternative would be the establishment of behavioral institutes independent of any one faculty."
6. Initiation of 4-year baccalaureate programs for technologists, two years common with current behavioral science programs, two years assigned to applied training involving applied settings.
7. Development of career programs in the public service, which would be attractive to qualified psychologists, in terms of responsibility for clients, and administrative and research opportunities.
8. High priority be assigned to developing technologists and technicians, making use of junior colleges, provincial technical institutes and behavioral studies institutes at universities, always recognizing the need to provide for the direct supervision of the technologists and technicians by certified psychologists.

He pointed out that the orientation of psychology as a discipline is increasingly away from a disease model of human behavior and toward one primarily concerned with the development of human resources.

He noted that the scientific evidence supports as practicable the concept of prevention of human distress at the individual, family and community levels without resorting to the idea of disease. The educational system, in his view, is becoming the necessary focus for "mental health" services which would be aimed at optimum development and redirection of limiting deviations before disabling distress occurred.

4. Roles of Psychologists and Their Aides

Without a clear definition of roles it is difficult, if not impossible, to determine personnel requirements for the staffing of institutions and organizations, to decide upon the nature and extent of education and training of any specialty and to evaluate the performance of personnel. The Chapter on Nurses revealed that their roles in mental health are not clearly established. The same condition applies to psychologists. Here again, however, there is a good deal of inter-professional agreement about the specific contributions which psychologists, and psychological technicians and technologists, should be making in the mental health field. That agreement, with the support of other professions, could be used to introduce a measure of order into professional preparation and employment.

Mr. R. G. Berry, Psychological Consultant to the Province of Ontario, was asked to set forth psychological job specifications in detail and in the form he believed they should exist. They are recorded in this section in their entirety to indicate how specific one can be about the roles of one mental health specialty. The specifications provided by Mr. Berry would also be useful, of course, in deciding upon training and duties of psychologists and their aides in Alberta. If this task is possible in relation to the psychological specialty, and clearly it is, it should not present serious difficulties for others.

PSYCHOLOGICAL JOB SPECIFICATIONS

by R.G. Berry, Consultant to
The Alberta Mental Health Study

PSYCHOTECHNICIAN 1

Class Definition

Incumbents of positions allocated to this class assist psychologists by carrying out a variety of procedures involving the administration and scoring of group tests or paper and pencil individual tests, data collection and analysis; they may operate, maintain, set up laboratory apparatus, and maintain animal laboratories and carry out duties for which they are specifically trained on the job. They may prepare case history summaries, code and tabulate data. They may prepare bibliographic surveys of scientific literature annotating, coding and listing for reference.

Qualifications

1. Grade XII education or the equivalent.
2. Experience in carrying out hospital duties relating to patient care and treatment or clerical, or technical work suited to the position the incumbent is to fill.

3. Personal suitability; ability to establish harmonious working relationships with professional personnel and patients, students or inmates.

PSYCHOTECHNICIAN 2

Class Definition

Incumbents of positions allocated to this class assist professional psychologists by administering and scoring a variety of psychological tests of ability, attainment, aptitude, interest, and personality. They report test scores and results, and describe observations gained during test sessions. In research studies they collect tests and other data, maintain local records and arrange testing appointments. They provide clerical assistance, operate, maintain, set up laboratory apparatus, order and keep test material and tabulate data. They may maintain animal laboratories. They may work on various aspects of data processing such as key punching, or computer programming. They may prepare bibliographic surveys of scientific literature annotating, coding and listing for reference. They make reports of work carried out.

Qualifications

1. Graduation from a College of Applied Arts and Technology as a Psychotechnician, or
2. Four years experience as a Psychotechnician in which ability has been demonstrated.
3. Personal suitability; ability to establish harmonious working relationships with professional personnel and patients, students or inmates.

PSYCHOTECHNICIAN 3

Class Definition

Incumbents of positions allocated to this class assist professional psychologists by administering and scoring a variety of psychological tests of ability, attainment, aptitude, interest and personality. They report test scores and results, and describe observations gained during test sessions. In research studies they collect tests and other data, maintain local records and arrange testing appointments. They provide clerical assistance, operate, maintain, set up laboratory apparatus, order and keep test material, and tabulate data. They may work on various aspects of data processing such as key punching, or computer programming. They may prepare bibliographic surveys of scientific literature annotating, coding and listing for reference. They assist with programs of training, education, behavior modification, guidance, counselling of individuals or groups. They make reports of work carried out.

Qualifications

1. Graduation from a university of recognized standing, or
2. Three years experience as a Psychotechnician 2 in which ability has been demonstrated.
3. Personal suitability; ability to establish harmonious working relationships with professional personnel and patients, students or inmates.

PSYCHOMETRIST

Preamble

The duties of positions allocated to this class are carried out by Psychometrists under the professional supervision of a psychologist. Duties include the collection of test data on individuals or groups of patients or inmates as part of an overall program of psychological service, either for psychiatric treatment or rehabilitation and reform purposes. They participate in ongoing programs of remotivation, behavior modification psychotherapy and rehabilitation as part of the treatment staff. Assistance to psychologists in gathering and processing data for research studies and in training non-professional staff may also be included. Staff in this class may be assigned research responsibilities in accordance with their level of training and experience.

It is expected that these employees will be planning to continue training to become psychologists and it is, therefore, expected that they would assume progressively more responsibility as they gain experience and training.

Exclusions

Positions where similar qualifications and experience are required or desirable, but where the duties performed are not directly related to professional psychological work are excluded from this series.

Class Definition

Incumbents of positions allocated to this class, under the supervision of a psychologist, assist in identifying emotional maladjustments, behavioral patterns and the mental level of patients, students or inmates by administering, scoring and interpreting a variety of intelligence, personality, academic, occupational and aptitude tests. Work assignments are regularly reviewed by the supervising psychologist who provides professional guidance and establishes the limits of responsibility assigned. These employees may make recommendations on the treatment, training and

placement of patients, students or inmates, subject to approval by the supervising psychologist. They prepare reports, incorporating their test findings, interview impressions and historical and biographic material which assist in the diagnostic and therapeutic decisions of psychologists, or psychiatrists. Similarly, they may participate in the collecting and processing of research data.

These employees interview patients, students or inmates and establish and test procedures to be used. They administer, score and interpret tests of intelligence, aptitude and personality and special diagnostic tests and procedures. Under supervision, they participate in psycho-therapeutic, counselling, guidance, training, education, rehabilitation and activity programs of an individual or group nature; assist in the application of research techniques and in the training of non-professional staff.

Qualifications

1. Graduation from a university of recognized standing and a Master's degree in psychology.
2. Personal suitability, ability to establish harmonious working relationships with professional personnel and patients, students or inmates.

PSYCHOLOGIST 1

Class Definition

Positions allocated to this class require responsible and complex psychological duties carried out in hospital training or correctional setting. The employees in these positions administer and interpret a complete range of psychological tests and in collaboration with other treatment staff plan, conduct and supervise individual and group therapy or behavioral modification programs for patients, students or inmates. In some cases these employees may receive administrative supervision from a senior psychologist but, characteristic of positions allocated to this class, they proceed with complete independence in their psychological work in keeping with their recognized professional status. Usually, positions in this class entail supervision by psychometrists. These employees function in collaboration with other members of the treatment staff composed of a variety of disciplines.

Employees in positions allocated to this class organize and develop a psychological service, in consultation with medical and other staff, regarding the needs of the population served by a treatment unit, out-patient clinic, day care center or rehabilitation unit. They participate in case conferences as actively contributing members of a clinic team in the establishment of diagnosis and in planning and assessing individual courses in treatment and rehabilitation.

These employees appraise the efficacy of treatment, rehabilitation, industrial and other programs and plan and coordinate remedial programs. They utilize a wide range of psychological tests, both standardized and of an experimental nature, in the assessment, description and measurement of dysfunction, disability and impairment and appropriate techniques of psychotherapy; play and behaviour therapy; vocational educational and parent counselling. They act as consultants on case posing difficult assessment problems. They normally supervise and assign duties to Psychometrists.

These employees may interpret the special needs and disabilities of patients, students or inmates to parents, relatives, teachers, institution officials or the personnel of social agencies. They may participate in public education through speeches, study groups, etc., in the community. They may participate in the instruction of professional and other staff and they perform related duties as required.

Qualifications

1. Registration as a Psychologist in Alberta.
2. At least one year's experience under the supervision of a psychologist in a mental health service or a reform or rehabilitative institution.
3. Ability to organize, coordinate and supervise a psychological service.
4. Personal suitability, ability to establish harmonious working relationships with other professional personnel, patients, students or inmates.

RESEARCH PSYCHOLOGIST

Class Definition

Psychologists in positions allocated to this class carry out responsible and complex research on human behavior. They plan, develop and conduct either applied or basic research. While the scope and orientation of the projects undertaken is subject to approval by their supervisor, they work with professional independence.

These employees undertake specific research studies on human behavior; interpret and evaluate complex scientific data; plan authorized research projects and prepare, or assist in the preparation of, reports for submission to Departmental authorities or research agencies such as the National Research Council. They originate new methods of study; review relevant scientific publications; make critical comparative studies of new established methods of behavior evaluation, treatment, care rehabilitation

and act as consultants to other professional staff on research matters.

These employees write reports and recommendations; prepare papers for publication in professional journals and literature; make regular progress reports on the research program and exchange technical information with other jurisdictions. They may assist in the training and development of subordinate assistants and perform related duties as required.

Qualifications

1. Registration as a Psychologist in Alberta and possession of the Doctoral degree in Psychology.
2. At least one year's experience in psychological research under the supervision of a Psychologist.

CHIEF PSYCHOLOGIST

Class Definition

The psychologists in positions allocated to this class are responsible as Department Heads, for the planning, assessment, and supervision of the psychological program in a facility. They are responsible to Clinical Directors for the psychological service in the facility and are expected to assist unit directors in providing programs. They consult with Clinical Directors and other staff in planning the development of appropriate psychological services and programs.

In all positions, these employees continually assess developments in psychological practice and originate new methods, techniques or systems of study and assessment to ensure provision of optimum technique and methods in the psychological service. They train and provide professional supervision of subordinate staff. They personally provide or assist in providing the required service. They may be responsible for or assist in, organizing and establishing rehabilitation remotivation or industrial therapy programs and may participate in staff training including psychological traineeship.

The employees in positions in this class act as consultants in difficult problems of psychological assessment and testify in court as expert witnesses, if necessary. They may plan and develop training methods for patients or inmate rehabilitation, industrial or behavioral change programs and develop methods of assessing the patients or inmates involved. They participate in the training of professional or other staff and may conduct some operational research.

As consultants to a Hospital Administrator, medical, professional or other advisory committees in a facility, an employee in this position may

be responsible for developing data processing, program evaluation, operational research or other systems of audit and study for the overall program.

Qualifications

1. Registration as a Psychologist in Alberta.
2. Doctoral degree in Psychology.
3. At least two years' experience in a mental health service or correctional institution and a record of proven competence.
4. Ability to organize, coordinate and supervise psychological service.

COORDINATOR OF TRAINING

Class Definition

Psychologists in positions allocated to this class are responsible for the training and supervision of trainees in the profession, within a training complex comprised of a significant group of hospitals, mental health clinics or other units. Centrally located within the complex, they arrange rotation and assignments; plan instruction; supervise applied work and evaluate the progress of trainees. They are responsible for the development of trainees and the maintenance of high professional standards of instruction.

These employees plan and supervise training programs; assess appropriate and effective methods of instruction; institute instruction techniques; place trainees in various settings within the complex and arrange for their rotation.

They plan and arrange for specific teaching, supervision and work, in each setting, including participation by other staff in instruction. When appropriate, they arrange seminars using consultants for instruction. They maintain liaison with other appropriate agencies and arrange visits by trainees.

They prepare evaluation of each trainee and the progress made; report on individual programs and on the training program as a whole and perform related duties as required.

Qualifications

1. Registration as a Psychologist in Alberta.
2. Doctoral degree in Psychology.

3. At least four years experience in a mental health service or correctional institution and a record of proven competence.
4. Ability to organize, coordinate and supervise an extensive psychological service.

REGIONAL COORDINATOR

Class Definition

The psychologists in positions allocated to this class are responsible as Regional Coordinators of Psychology, for the planning, assessment and coordination of the psychological programs throughout the region in facilities which provide mental health services, e.g. psychiatric treatment units, adolescent or child treatment or retraining units, out-patient department, day care center, and rehabilitation services. They are responsible for the psychological services in the entire region and are expected to assist the director responsible for each facility to establish the psychological service appropriate to the program in that facility. They act as consultants to clinical directors in planning and developing appropriate psychological services and programs for facilities and in providing information on standards and staffing.

In all positions, these employees continually assess developments in psychological practice and originate new methods, techniques or systems of study and assessment to ensure provision of optimum techniques and methods in the psychological service. They may personally provide or assist in providing service in one of the facilities. They may be responsible for or assist in, organizing and establishing rehabilitation, remotivation or industrial therapy programs and may participate in the training of professional or other staff.

As consultant to Hospital Administrator, medical, professional, or other advisory committees in a facility, an employee in this position may be responsible for developing data processing, program evaluation, operational research or other systems of audit and study for the overall program.

Qualifications

1. Registration as a Psychologist in Alberta.
2. Doctoral degree in Psychology.
3. At least four years experience in a mental health service or correctional institution and a record of proven competence.
4. Ability to organize, coordinate and supervise an extensive psychological service.

5. Other Psychologists' Views

This section will summarize the submissions received in 1968 from Dr. B. P. Frost of the University of Calgary (from 1972 Head of the Department of Educational Psychology there) and from the Psychology Department at Alberta Hospital, Ponoka.

Dr. B. P. Frost

There is a great need for day hospitals, night hospitals, out-patient clinics, etc., for helping severely neurotic and psychotic patients (child or adult). There is also a need for more financial and other help for the C.M.H.A.'s White Cross Centres. There is no place in modern times for a huge mental hospital of the Ponoka type. It is also important to keep in mind that only through variety and rigorous evaluation of diverse theories and techniques that the most efficacious treatment methodologies will emerge.

Residential schools for emotionally disturbed children are very much required.

To facilitate early diagnosis and treatment of disorders a "risk register" should be established, beginning with the names of those children whose birth was unsatisfactory. The actual compilation and keeping of the register should be the responsibility of the Medical Officer of Health.

School psychologists should be provided for rural areas. The Government should up-date its policies regarding school psychologists. For example, at present the Government will only subsidize those psychologists, who hold teaching certificates. This policy requires revision.

School psychologists can only deal with school aged children. A more satisfactory situation would exist if children, upon reaching the age of two, should be examined by a medical officer and a psychologist in order to determine if the child is suffering from any disability of mind or body. It then becomes the duty of the educational authority to ascertain what children in their area require special educational treatment.

The present salary scale for clinical psychologists in the service of the Government of Alberta requires immediate upward revision. Salary scales of school psychologists need to be articulated in several levels with clear educational and experiential criteria.

Publication of the existing Dominion Government's publication Canada's Mental Health should be expanded. There is a need for increased Western coverage by this periodical.

Psychology Department, Alberta Hospital, Ponoka

A greater degree of autonomy should be granted to hospitals such as the AHP, e.g., in the areas of in-service training. Within the hospital, autonomous units should be established.

There should be more in-service training for staff psychologists, e.g., internship programs. A significant increase in the number of

psychologists on staff is also required. Provisions should also be made for further continuing education of psychologists, e.g., opportunities to attend seminars. Psychologists' salaries should be brought in line with those of other provinces, e.g., Ontario.

Provisions should be made to enable research to be carried on within the hospital. One full-time clinical psychologist and one full-time social psychologist should be involved in research; research assistants from the Universities of Alberta and Calgary should carry on research; twenty per cent of the staff clinical psychologists' time should be spent on research projects.

Adequate physical facilities and equipment should be provided. At present nine psychologists share four offices; testing materials are inadequate and must be shared by the psychologists; a central library is required.

A need exists for the establishment of proper facilities for the treatment of adolescents within the mental hospital. This unit should be adequately staffed with, for example, a school teacher, nurses, and psychologists.

A well-rounded follow-up treatment program including foster home and counselling should be established.

CHAPTER 9

ALBERTA HOSPITALS AND THE HOSPITAL ASSOCIATION

1. Alberta Hospital Association

The Alberta Hospital Association makes this submission¹ on behalf of its member hospitals and nursing homes. The content has been prepared by a special committee and has been reviewed and approved by the Board of Directors of the Association.

The Association has not undertaken to cover the whole field of mental health care, but restricted itself to matters which relate to the role of hospitals in Alberta. It is felt that general hospitals have a definite role in seeking solutions to many community health problems, that maximum use should be made of community resources, and that regional coordinating councils should be involved in mental health care where possible.

The committee has tried to provide useful information within that scope, to offer useful opinions where its members have experience and expertise, and to avoid overlap or repetition of points of view to be presented by other interested groups and associations.

It would be useful to establish the role of a regional hospital. The committee examined and generally approved the proposal of the Lethbridge Municipal Hospital Board for the establishment of a regional mental health unit for Southeastern Alberta. The regional hospital should have a thirty-five bed psychiatric unit and would make available clinical facilities to smaller centers. The unit would provide qualified personnel to whom local physicians could refer patients, and from whom the physicians and related personnel could receive appropriate education for local development. The recommendations and commentary at Appendix "A" are based upon the Lethbridge proposals and are deemed an essential part of this submission.

Definition

Mental health is a term having many connotations. Within this presentation, the person who is not mentally healthy is not well adjusted; is frequently worrying, possessed of thoughts and feelings of anger, anxiety, depression, distrust and fear or is emotionally disturbed.

¹ The submission has been reduced in length and altered slightly in form.
W.R.N.B.

Hospitalization

The extent of the problem is almost inestimable but, using hospitalization as the criterion at any given time in Canada there are about 75,000 people occupying hospital beds because of mental illness. Half the hospital beds in Canada are used for the care of psychiatric patients; however, many less than half of the beds in general hospitals are available for this purpose. One out of every ten or eleven Canadians requires hospitalization and treatment for mental illness in his lifetime and one out of ten Canadians needs treatment now for mental illness. Six per cent of the inpatients in general hospitals have alcoholic problems, which involve psychiatric considerations to a very marked degree. The last figure comes from a 1967 study in Alberta sponsored by the Alcoholism Foundation.

Medical Care

Only twelve per cent of the practising physicians in Canada are qualified specialists in psychiatry. A great part of the care for patients with mental diseases is provided by family physicians, who represent about one-half of practising physicians in Canada. Most physicians state that at least half of the patients visiting them for care of physical complaints are found to have emotional problems, apparently or totally responsible for the complaints. Family physicians report that fifty to sixty per cent of their practices have a psychiatric nature; frankly, they treat large numbers of psychiatric patients.

Cost

The treatment of persons with mental illness is very expensive and, in Canada, equals the cost of other types of treatment. Added to the direct costs of mental illness is the loss of efficiency, increase in accidents, delinquency, divorce, alcoholism, crime, and family breakdown; many of these elements are difficult to define and almost impossible to cost.

Facilities and Programs

Present Facilities

Psychiatric facilities are inadequate in cities with psychiatric units in general hospitals. In Calgary and Edmonton, there are not enough psychiatric beds in the general hospitals. Patients, who can be admitted, receive a lower standard of care because of the rush to get them in, give them a modicum of treatment and discharge them so others may be admitted. In other metropolitan areas, such as Lethbridge, where psychiatric facilities are inadequate or non-existent, the problem is magnified greatly. Special types of psychiatric units are needed for forensic cases, for disturbed children and for child guidance clinics. Some patients with a

chronic mental disease are not cared for adequately. These should be in special units associated with sheltered workshops, which could also be used for other psychiatric patients from auxiliary or mental hospitals.

Training: Adults and Children

Training schools with active programs should be established for persons who are chronically demented. If they are admitted to general hospitals, they should have an adequate diagnosis, a plan of treatment and be discharged to a training school. The number by-passed and not cared for because of the urgency of more acute conditions is not known. Nor is it known what can be done for them, whether they can be trained or re-trained. A good example is a patient suffering from chronic schizophrenia. While the effect of institutional confinement on such patients is not good, the need for training school facilities for them at certain periods in their illness is absolutely critical. No immediate solution for the proper care of such patients is apparent. They become very dependent and that problem must be resolved. Some of them might well not become chronically ill, if they receive adequate care and proper post-hospital follow-up from the general hospital.

In appraising the problem of the possibly chronic patient it was seen that pediatric and adult patients should be separated. Child care usually can best be provided elsewhere but, if it is necessary to hospitalize children, their care program must be extensive; it requires a long term stay, a high patient-staff ratio, and it is costly. They also require long term follow-up so community agencies and services must be available to help them. In the hospital, these children need more freedom, more staff, more programs for their development and, most of all, understanding by the medical and paramedical professions. There are less specific forms of therapy for children and there are not enough personnel trained in the care of mentally disturbed children.

It would seem that the care facilities for children with severe mental diseases should be near a pediatric hospital or in a closely associated unit so the services of the hospital can be used effectively.

Psychiatric Units in General Hospitals

All general hospitals with over two hundred beds should have a psychiatric unit; a reasonable rule of thumb would be ten per cent of beds for psychiatric care.

Local physicians can care for many psychiatric ills without a psychiatric unit but, where they can not, they should have a psychiatric consultant available to them. Local physicians, nurses, social workers, etc., can be very helpful and should be involved in psychiatric care programs.

With adequate community services, one bed per thousand population is thought to be an adequate ratio. In communities without such services, approximately four beds per thousand would be more realistic.

Certain areas in Alberta need psychiatric units as bases for regional programs. They are: Lethbridge, Medicine Hat, Grande Prairie, Red Deer and Drumheller. In addition, of course, Calgary and Edmonton should continue as regional centers and be developed to the maximum with all their general hospitals incorporating psychiatric units.

Considering thirty-five beds a suitable unit, two such units would be needed in Lethbridge. They would allow for referral and admission of patients from the areas served by Lethbridge hospitals. Other regional centers should have one unit each.

Auxiliary Hospitals

Auxiliary hospitals should play a definite role, in association with sheltered workshops and rehabilitation programs. It is necessary to allocate some beds in auxiliary hospitals for the use of patients who have psychiatric problems in addition to other diseases. A good program of progressive care should be developed to meet their needs without delay.

Nursing Homes

The needs of patients in nursing homes for mental health care is not met well, resulting in patients being "by-passed." They require a long term, custodial care. Many have chronic mental and physical disease and need adequate rehabilitation facilities with sheltered workshops and a progressive patient care plan, as indicated.

Certain patients in auxiliary hospitals and nursing homes require admission to acute psychiatric care units in general hospitals, and such admissions should be facilitated. They should have access to psychiatric units on a basis equal to non-hospitalized or non-institutionalized people.

Geriatric Patients

The term "senility" is not very useful. People, who have borne such a label, might be described more accurately as having mentally degenerative diseases; their activities are restricted and they have psychological burdens. Some also have physical disabilities and they all need a good supporting family physician who has available to him a psychiatrist and other necessary ancillary personnel. Beds in psychiatric units of general hospitals should be available for these patients also, when needed.

A special report on the long term care patients as seen in nursing homes, prepared by the Calgary Auxiliary Hospital and Nursing Home District No. 7, dated February 13, 1968, is attached as Appendix "B".

Location of Psychiatric Facilities

Mental health centers should be located in relation to medical schools. This does not mean that there is no longer a need for psychiatric beds in general hospitals, but a center for research, investigation and special studies would serve the community better if it is in a center related to a medical school.

In centers where there are no medical schools, psychiatric facilities should be provided in one coordinated unit, consistent with the idea of regional programs.

A strong regional center would support consultants to serve the region. A telephone consultative service arrangement and back-up facilities for physicians and other related care personnel could be provided. There must also be beds for short term admissions of acute psychiatric patients by local physicians, who may provide emergency care under the guidance of a regional consultant. Adequate provision should exist for the transfer of such patients to a regional center.

Adequate follow-up care from a regional center after discharge, including involvement of a physician, public health and other personnel, must be planned in detail. (See Appendix "A").

Local hospital board control and community involvement are sources of great strength. The functions of the local board must include good public information programs and the engagement of interested personnel in support of treatment and follow-up programs.

Regulations under The Mental Health Act should be broadened to designate all approved hospitals in Alberta as hospitals under the Act, rather than the few named now.

Mental Hospitals

Mental hospitals operated by the Province of Alberta should not continue to function in isolation. They should become members of the Alberta Hospital Association to obtain a better understanding of the problems and programs in general hospitals; the converse would also result. Better understanding would facilitate the transfer of patients to provincial hospitals from general hospitals and the after-care of released patients.

Additional mental hospitals should not be built in the Province because it is easier to build, staff and operate psychiatric units in existing general hospitals. This should be the approved and accepted method of developing psychiatric facilities. Medical doctors and paramedical personnel in hospitals and in the communities can best serve the needs of psychiatric patients in their communities.

Post Mental Hospital Care

Many complaints continue to be heard because of inadequate post-discharge care of patients released from Alberta Hospitals to urban centers. This is a major community problem and has recently been considered by the Canadian Mental Health Association. It is of direct hospital interest in that it may well delay discharge and restrict the numbers to receive care from community resources.

Forensic Clinics

Many of the ills attributed to mental aberration can be alleviated by the provision of adequate forensic clinics. Such clinics diagnose and treat pathological conditions, such as sexual deviation, provide early preventive services and encourage responsible self-control. Forensic clinics should be established in Edmonton and Calgary in association with provincial hospitals.

The Family Physician

The family physician is the primary physician who needs facilities to treat the fifty per cent or more of his practice who have psychiatric problems. If the facilities, services and adequate supporting personnel were available to him, a large part of the burden now thrust upon the provincial hospitals, and some general hospitals with psychiatric units, could be lifted. In the cities with increasing population and incidence of mental diseases, serious consideration must be given to such development.

The family physician works within a decentralized program in cities, towns and rural areas, and this is obviously another reason to support the use of general hospitals for psychiatric care. Physicians, with sufficient training and experience, could be sent out to regional centers and to the smaller areas to study their problems and prepare themselves to provide support of personnel located in the smaller areas. Such physicians and ancillary personnel would have to be subsidized and supported adequately. They would provide an additional pool of useful people who might even decide to practise in the smaller centers.

Educational programs and experiences should be made available for family physicians to up-date and extend their professional knowledge. Because of the urgency for the care of patients with other than mental illness, family physicians are hard pressed. They may not consider it necessary to continue their education regarding the treatment of mental diseases. This last point is considered very important.

The development of adequate facilities and services in general hospitals would encourage the continuing education of family physicians from rural and less populous areas. These physicians would be prepared by good educational programming to return to their communities, able to render necessary services which they are not now capable of providing.

Team Approach

Successful methods of treating mental patients can be applied in general hospitals. A team approach to treatment is best and is particularly suited to the regional unit concept. The team would be composed basically of psychiatrists, clinical psychologists and psychiatric social workers. Working with physicians in rural areas, they would provide the professional assistance needed in those communities.

Recommendations

1. The treatment of persons having mental illness should be transferred from special mental hospitals to general hospitals. Mental hospitals should be maintained only to care for patients who are chronically ill, for forensic cases, to attend to special childhood mental diseases, and to provide a locale for mental health and guidance clinics. (Adoption of this concept would result in the majority of mentally ill persons being cared for at their local and community hospitals.)
2. Regional mental health clinics should be established to enable local (community) hospitals to care properly for local citizens; such clinics should function in support of local hospitals and physicians.
3. Auxiliary hospitals and nursing homes should be developed to the fullest extent to support the active treatment hospitals.
4. Recommendations #14, 42, 44 and 47 of the "Report of a Consultation to the Minister of Public Health on the Psychiatric Services of Saskatchewan, 1967," should be accepted.

Sections #25-30, inclusive, and #39, of the "Frazier" Report (named in Recommendation #4) are especially relevant to the problem of improving Alberta's mental health services and should be considered in that context.

APPENDIX "A"

REGIONAL MENTAL HEALTH UNITS

The establishment of regional mental health units should be considered seriously. The Association submits the following proposals in that regard.

1. That mental health facilities for general hospitals should be decentralized.

The following points are offered in support.

- a. Because there is a shortage of psychiatrists, almost all mental health problems will be dealt with first by the family physician. We believe he must remain in contact with, and be ultimately responsible for, his patient until he is returned to regular living.
- b. There is a stigma attached to the present type of centralized governmental institution.
- c. Because of time and expense, family and friends now find it difficult, if not impossible, to visit the centralized mental hospitals.
- d. Return to the community would be made easier.
- e. Concern of the community would be applied to keep mental health services in the forefront and up to standard.
- f. Earlier diagnosis, treatment and admission to hospital would be possible.
- g. There would be less disruption of normal life.
- h. The resources of the home environment could be used.
- i. Day and night treatment services would be possible.

2. The administration of physical and mental health services should be integrated.

- a. On the provincial level one governmental agency should administer all hospital care, physical and mental in the interest of: removing discrepancies between the standards of mental health care and physical care; providing a ready comparison of standards of care; and contributing to economy of administration.
- b. At the local level, there should be a concerned group of selected citizens, directly in charge, to insist on proper standards, and to

educate the community to support them. The family physician could then be part of the administration of the treatment center, feel a greater responsibility, and take a greater interest.

3. Mental health facilities should be provided in general hospitals.

- a. The psychiatric patient would be recognized as a medical problem.
- b. The stigma now connected with mental health would tend to be removed.
- c. The family physician, who daily practices in the general hospital, would be used more fully, and be encouraged to follow up and take responsibility for patients who are mentally ill.

(There is a shortage of psychiatrists, psychiatric nurses and other personnel needed in the treatment of the mentally ill and every effort must be made to use the family physician, the general duty nurse, and other general hospital personnel. We are satisfied that this can best be accomplished by total integration of the mental health treatment facilities into the general hospital.)

- d. Staff recruitment would be easier because general hospital employment is a more acceptable environment.
- e. The proposed integration recognizes the overlapping of physical and mental health problems.
- f. All necessary facilities of the physical illness treatment plant would be available for mental health patients.
- g. Standards of care for the mentally ill and physically ill would tend to be equalized immediately.
- h. The plan would permit and encourage greater cooperation and communication between the psychiatrist and the family doctor.
- i. The family physician's training and qualifications for the care of the mentally ill would be upgraded.
- j. There would be easier transfer of the care of a patient back to the total control of the family physician and hence back into the community.
- k. Medical and nursing staffs would be concerned for the improvement and upgrading of mental health facilities in a hospital for which they had some responsibility.

4. Almost all mental health services should be located in one building.
- a. The services should include: child guidance; in-patient care, with emphasis on active treatment; physical treatment facilities such as occupational and physiotherapy; day treatment service; night treatment service; out-patient service; consultation service; emergency service; facilities for the treatment of alcoholism and drug intoxication; and an office for home care programs.
 - b. We believe that centralization of mental health services would have the following attributes:
 - (i) A comprehensive program which would eliminate gaps and overlaps;
 - (ii) A comprehensive record keeping service;
 - (iii) A greater degree of follow up;
 - (iv) All facilities and services would be readily available and used more effectively;
 - (v) Communication between all concerned with the various aspects of mental health would be encouraged and facilitated;
 - (vi) Administrative and capital costs would be reduced.
5. Specialized institutions are needed for forensic problems, emotionally disturbed children and long term geriatric cases.
- We emphasize, however, that every effort should be made to give diagnostic service and short term treatment for children and geriatrics at the mental health facilities of general hospitals.
6. All community facilities should be utilized in the treatment and prevention of mental illness.
- a. A program for the use of the active treatment hospitals, auxiliary hospitals and nursing homes should be adapted to the treatment of psychiatric patients.
 - b. A home care service operating out of facilities in the general hospital should be provided.
 - c. Offices and personnel should be established in the general hospital to coordinate mental health treatment resources, including, churches, Y.M.C.A.s, schools, Alcoholics Anonymous, university psychology departments and every other useful facility in the community.

- d. Use should be made of a preventive health services program to encourage community organizations which participate in the prevention, treatment and rehabilitation of the mentally ill.

The establishment of forensic clinics in regional centers is necessary and the extent and location of these clinics should be determined by responsible persons in the regional mental health clinic.

7. Services designed to prevent mental illness should be developed.

- a. Use can be made of school counselling programs to provide referrals.
- b. The emphasis should be on early detection and early treatment of mental illness, in the community, at a general hospital.
- c. Specific recommendations for a unit, such as the one proposed for the Lethbridge area follow:
 - (i) The immediate provision of a decentralized total mental health care center.
 - (ii) The facility to be an integral part of the general hospital.
 - (iii) The facility to include the services mentioned in paragraph (4) above.
 - (iv) The facility to be administered by a citizens' board, which would have responsibility for the administration of the total facility, including the general hospital, the psychiatric facilities, and other mental health services.
 - (v) The Hospital Services Section of the Department of Health should be responsible for both physical and mental health care services.

In summary, the Association accepts the philosophy that mental health is a community problem, which should be treated in the community. This can best be accomplished by treating the "whole man" in the general hospital; by encouraging the greater use of the family physician in the treatment of mental illness; by the development of a home care program; and by employing and coordinating those facilities which already exist in the community for the treatment and prevention of mental illness.

APPENDIX "B"

CALGARY AUXILIARY HOSPITAL AND NURSING HOME DISTRICT NO. 7

6909 Fourteenth Street S.W.
CALGARY, Alberta

February 13th, 1968

The Board
Calgary Auxiliary Hospital and
Nursing Home District No. 7
CALGARY, Alberta

Gentlemen:

The attached report has been based upon the Nursing Home Survey Report, and discussion with Mr. J. D. Campbell, the Medical Advisory Committee, the Joint Conference Committee and Senior District Staff, for your consideration.

Respectfully submitted,

P. Fry
District Administrator

Att.

1. Confused Patients

At the time of the nursing home survey 5.28% (69) of the patients were assessed as requiring "Special Facility" care.

Experience has demonstrated and continues to demonstrate clearly that persons in this category present problems which seriously affect the standards of our district program.

a. Care Requirements Not Met

There is ample evidence that many patients who are unmanageable in nursing homes can, with proper care, be improved to a degree that they can be managed in nursing homes.

The nursing home program is not designed to provide the type of care these people require, nor does it appear practical to do so.

b. Effects on Other Patients

- (i) The more confused patient makes demands on the time of the nursing home staff to a degree that other patients receive less attention than they require.
- (ii) The confused patients disturb other "normal" patients and, in some instances, actually use physical violence to annoy other patients.
- (iii) The confused patient is the greatest single source of exaggerated complaints.

c. Public Image

The mingling of very confused patients, who are noisy and anti-social, presents a most undesirable impression on visitors to the nursing home.

d. Resistance to Transfer

When such a patient is admitted to a nursing home, or an in-patient suddenly becomes very agitated, the problem can completely disrupt the operation of the home, and very seriously affect the morale of patients and staff.

Such a problem, which should be solved as quickly as possible, often takes days or even weeks to get the required action.

- (i) No special facilities exist for such patients and the majority are not necessarily in need of committal.

- (ii) The physician concerned is not readily available and in most cases is reluctant to move the patient.
- (iii) Relatives often seriously object to moving the patient, particularly if there is a suggestion that the patient might be committed.
- (iv) Nursing home staff often resist transfer, through disinterest, fear of incurring the displeasure of the relatives and, in some cases, the physician in charge of the case.

Nursing home staff, in many instances, aggravate the situation, by not bringing problem cases to the attention of the Director of Nursing Home Services until the situation has grown serious, and then they expect instant action. In this situation, transfer is resisted because those concerned often do not understand why a patient, who, as far as they know, has been adequately managed, suddenly becomes a pressing problem.

Recommendations

1. To ensure that a situation created by a very confused patient is attended to as quickly as possible, the approval for continuing nursing home care should be withdrawn.

The procedure would be that, when brought to the attention of the Director of Nursing Home Services, she would discuss the situation with the Chairman of the Assessment Committee or the Chief of Staff and, if he agreed, she would notify the Nursing Home Operator concerned that the patient was no longer approved for nursing home care.

Since the nursing home operator is obliged, under the Nursing Home Regulations, to obtain the necessary care for a patient, the onus for initiating the necessary action would be clearly placed where it properly belongs.

2. A special facility should be organized in the George Boyack Nursing Home.

One nursing unit should be staffed with psychiatric-orientated personnel, specializing in the care of confused nursing home patients with the cooperation of the psychiatric departments of the active treatment hospitals.

3. The follow-up service being developed in cooperation with the Department of Psychiatry of the Foothills Hospital should be developed to the fullest extent.

4. An in-service education program should be developed for nursing staff to familiarize them with the care and management of confused patients.

2. Identification of Nursing Home Patients

The Nursing Home Survey Committee identified a nursing home patient as being

"one whose personal and medical care needs can be provided for by nursing aides and orderlies under the supervision of Registered Nurses, with a minimal requirement for direct personal attention from Registered Nurses."

This is an accurate description of a nursing home patient and, indeed, is the first 'positive' description.

Recommendation

It is recommended that this description be adopted by the District and, for the guidance of all concerned, be supplemented with the following:

"Criteria for acceptance of patients in a nursing home, broadly speaking, are not wholly dependent on the diagnoses or conditions but on the inability of the individual patient to carry on at home where there is no one able or willing to assist her. Although pathological conditions do not exclude the patient from the nursing home, the disease processes should have reached stability or quiescence and require minimal care to remain so."

More specifically, the criteria for acceptance are as follows:

1. Anyone, regardless of age, who requires assistance in personal functions, that is, feeding, dressing, toileting, supervision over medication and assistance in mobility. This may be total assistance in all these functions or partial assistance in any one of these functions.
2. Anyone, who because of aging and/or disease, is mentally incompetent and requires care and supervision of her daily activities for her own protection, but is not hostile and noisy, destructive or socially unacceptable.

Examples of patients, who, because of their condition, are NOT considered suitable for admission to nursing homes, include:

1. Patients whose mental condition is such that they disturb other patients and present difficult management problems.

2. Patients whose status changes frequently and who require re-admission to hospital, e.g.
 - a. The brittle diabetic who needs frequent insulin adjustments and strict diet control.
 - b. Patients who have unstable or poorly controlled congestive heart failure with resultant episodes of acute pulmonary edema.
 - c. Patients with progressive debilitating disease who have frequent exacerbations - multiple sclerosis, etc.
 - d. Patients with chronic bronchitis or emphysema who have frequent respiratory crises and who may require oxygen therapy.
 - e. Patients with serious and severe peripherovascular disease - gangrene, etc.
 - f. Severe asthmatics.
3. Patients who require sterile dressings and procedures; those with catheters, open draining wounds, large varicose or decubitus ulcers.
4. Incontinent patients whose incontinence is due to retention with overflow because of obstructive conditions - cancer, benign tumors, cystoceles, etc.
5. Patients who have constant dribbling of urine due to irritation from a catheter or chronic infection.
6. Cancer patients who are terminally ill and because of the site of the cancer and/or metastases become frequently obstructed in bowel or bladder, those who are unable to retain nourishments and require close supervision to ensure adequate intake and those who require frequent hypodermic injections for the control of pain.
7. Patients who would benefit from physiotherapy. Examples of such patients are those with fractured limbs, cerebrovascular accidents, and Parkinson's Disease where such therapy would help to attain and retain optimum muscle function and prevent contractures.
8. Patients who require extensive steroid therapy, as in severe rheumatoid arthritis, ulcerative conditions of the eyes or intestines and severe dermatitis. The resultant risks of sodium retention, edema and congestive heart failure require close medical attention.

9. Patients who require drug therapy and close medical attention to stabilize a condition. Examples are the extremely confused and agitated patients and the uncontrolled diabetic in need of diet or insulin adjustment.

The type of care required by each patient should determine admission to a nursing home or to an auxiliary hospital.

Nursing home care provides for the personal needs of the patient - help and supervision in the activities of daily living, including supervision of medications.

Auxiliary hospital care, on the other hand, provides for professionally supervised drug, physical and/or dietary therapy for the restoration and/or maintenance of health and independence, for which the auxiliary hospital is designed, equipped and staffed.

3. Role of the Graduate Nurse

Related to both the preceding sections of this report is the misunderstanding of the role of the graduate nurse in the nursing home.

- a. The graduate nurse has been trained and is generally competent to nurse patients identified as not being nursing home patients. This factor is often a reason for patients remaining in nursing homes when they require care beyond that which it is intended the nursing home shall provide.

When the graduate nurse is providing direct patient care, she does so at the expense of the over-all patient care in the home; general staff are not being properly supervised; and she is not in a position to utilize her professional observation ability to spot changes in the conditions of other patients.

- b. The very presence of a graduate nurse in the nursing home and the misunderstanding of her role is often the deciding factor which results in an individual physician leaving his patient in the nursing home when informed that the patient is in need of 'Professional Nursing Care'.
- c. This misunderstanding is, of course, extended to patients, relatives and other staff.

Recommendation

It is recommended that the role of the graduate nurse in nursing homes be defined as:

- a. Exercising her special nursing knowledge of observing the patient's condition and needs with a view to:
 - (i) Ensuring the personal services provided are consistent with his needs to the end that only those things a patient cannot do for himself are provided and that independence is assured within the limitations of his abilities.
 - (ii) Ensuring that changes in patients' conditions which, in her professional opinion, should be reported to the physician concerned are in fact reported and that the physician's instructions are accurately recorded and carried out.
- b. Being responsible for medications if the only graduate nurse in the home, or the one designated.

4. Assessment Form

The difficulty in obtaining accurate and sufficient information on which to base a meaningful assessment of the care requirements of an individual patient was very evident during the survey.

The care requirements of the individual patient extend over a wide range of personal services, supervision and medical factors. It was agreed that the form used for the survey, together with the active treatment hospital discharge summary would constitute a better profile of the patient than the system in use.

Recommendation

That the Rockyview Hospital be approached and requested to conduct a trial of a new system of assessing patients whereby

- a. Initial application would be made on a modified version of the form used by the Survey Committee.
- b. When the discharge summary is typed at the Rockyview Hospital, an additional copy would be forwarded to the auxiliary hospital to which the patient was admitted.
- c. Both documents would become part of the patient's record and form the basis for assessment.

2. Beaverlodge-Hythe General Hospital District No. 32¹ Beaverlodge, Alberta

The medical records of the Beaverlodge Hospital for 1967 indicated that 16 patients were admitted for a diagnosis falling in the field of mental health. These patients accounted for 76 patient days. In addition, several patients were referred directly to Edmonton as facilities to treat them locally or in the immediate area were not available.

Patients being admitted with a mental health problem can not be expected to receive the care in an active treatment hospital that they would in a mental care hospital as facilities and medical consultation are not available.

Also, because of the nature of an active treatment hospital, a mental patient creates problems of extra staff and this results in increased hospital costs.

Alberta Hospital Edmonton (Oliver), is the closest facility available to Peace River region residents. From our district this involves distances of 310-360 miles and herein lies much of the difficulty in dealing with patients requiring mental health care.

This distance factor involves several primary considerations for improvement in mental health care in the area, cost, patient attitudes, patient care and rehabilitation.

Cost

Transportation of patients is accomplished through public transportation systems, private conveyance or R.C.M.P. In many cases public transportation is unsuitable and private conveyance must be used. In times of stress, this is an added burden on the family of the patient and in many cases, treatment of the individual is delayed. In many cases the R.C.M.P. have transported difficult patients to Edmonton at no charge to the family, but nevertheless this is an added overall cost to the people. Visits to the patient by his family are also curtailed and what effect the absence of the patient's family has on his or her recovery, we cannot say.

Patient Attitude

Even with the present trends of thought regarding mental illness, the fact is that there is still a stigma attached to mental hospitals, or

¹ A brief submitted by Dr. P. Pankiw, Board Chairman and Mr. L. W. Jones, Administrator.

mental illness. Having a wing of an active treatment hospital assigned for mental health care may have a psychological effect on a patient that would be of some benefit.

We also know that many people are still reluctant to accept mental treatment. The thought of travelling a full day away from home to arrive at a treatment area increases this reluctance. Many individuals who may need minor treatment often decide to dispense with it rather than take time off from their work or business to travel such a distance. In many cases, later treatment is unnecessarily prolonged. The distance factor places a further burden on the disturbed individual knowing he is going to be away from home with much less chance of seeing his family or friends.

Patient Care and Rehabilitation

Because of distance, the psychiatrist often is unable to obtain information from or about the immediate family, which might aid in treatment. This may also hinder rehabilitation. Referral or consultation regarding patients, who need minor care, would be expedited if mental health facilities were available in the area, instead of 300 or more miles away.

On the basis of above facts and factors, the Beaverlodge-Hythe General Hospital District #32 Board, and Medical Staff recommend that policies on mental health care be re-examined with the view to establishing mental health facilities in the Peace River region.

CHAPTER 10

ALBERTA ASSOCIATION FOR RETARDED CHILDREN¹

Foreword

The Alberta Association for Retarded Children is a voluntary organization, started in 1954 and incorporated under the Societies Act in March 1956. A province-wide body, its Board and committees generally comprise representatives from sixteen local associations for retarded children.

The Alberta Association has served largely as a coordinating and developmental agency working closely with the local associations, Government departments and other public agencies, the Canadian Association for Retarded Children and the "Crusade Projects."

It has directed its efforts toward the development of more local associations and schools for retarded children. It has also assisted the local associations to raise funds to establish schools and other programs. It provides public information and publicity to inform Albertans about mental retardation and the needs and services of the associations throughout Alberta. A quarterly magazine, New Horizon, with a circulation of about 4,000, is published.

The Alberta Association is one of nine provincial associations affiliated with the Canadian Association for Retarded Children. The latter represents over 20,000 members from local associations across Canada, all striving to establish new programs and services to meet the back-log of needs of the mentally retarded.

Professional advisory councils, representing a range of disciplines, have been established by the Canadian and the Alberta Associations for Retarded Children. Their function is to provide guidance to the associations on scientific and research problems.

The national Association, with the assistance of provincial and local associations, was instrumental in initiating fourteen Crusade Projects across Canada, each concerned with some aspect of mental retardation, e.g. research, industrial and vocational training, diagnostic clinics, and residential care. The three projects being conducted in Alberta are: Centre for the Study of Mental Retardation, University of Alberta, Edmonton; Industrial Research and Training Centre, Edmonton; Vocational and Rehabilitation Research Institute, Calgary.

¹ This is a condensed version of the original brief from the Association, whose name has been changed to The Alberta Association for the Mentally Retarded. W.R.N.B.

Collectively, we are most grateful to the Governments of Alberta, and Canada, and for the many donations that have made all of these activities possible.

Much has been done to meet the problem of retardation, but the incidence and the needs of our mentally retarded have grown apace. The associations, centers and institutes in Alberta are very much aware of the urgent need for additional facilities and programs. We are anxious to work in cooperation with one another and all Government agencies to develop a comprehensive plan to meet the needs of mentally retarded. This brief will set forth a plan to cover the next five to ten year period.

Objectives of Brief

The objectives of this presentation are to: promote the general welfare of the mentally retarded of all ages in Alberta, at home and in the community, by training and education; in institutions, by services operated by local associations for retarded children; and to prevent mental retardation.

To achieve these objectives it is essential that all agencies working in the field of mental retardation, both volunteer and governmental, work in close coordination and cooperation in a comprehensive, all-out effort to plan, organize and develop programs to meet the needs of the mentally retarded.

Summary of Recommendations

1. That the Province of Alberta establish a Mental Retardation Board: comprised of interdepartmental and interagency representatives, responsible for making recommendations to the Executive Council for the development and maintenance of a comprehensive program to combat mental retardation.
2. That financial support for research in the field of mental retardation be greatly increased, to identify causal factors, develop methods of prevention, evaluate present facilities and services, and explore new and promising avenues of treatment, training and education.
3. That home-based and community-centered facilities and programs be the primary focus of service for the mentally retarded, with support from improved diagnostic and assessment clinics, home training, parent counselling, day schools, day care centers, community residences and workshops.
4. That pre-school programs be established, with financial assistance from the Provincial Government, to give our young mentally handicapped persons maximum opportunities for development during the critical early years.

5. That improved and expanded programs of training and education be made available to all retarded persons, implemented as follows:
(1) conduct a thorough province-wide survey to identify the mentally retarded and their needs, (2) increase the present provincial schedule of grants for capital and operational costs, (3) arrange for the inclusion of trainable mentally retarded children within the public school systems of Alberta, in consultation with private associations now operating schools, (4) offer specific incentives and increased opportunities to prepare teachers of retarded children, (5) encourage research aimed at developing the strengths and ameliorating the weaknesses of the mentally retarded, (6) extend the present regulations governing the age for school attendance both downward and upward, and (7) ensure that training and education for the retarded is accessible through day schools and, where necessary, through regional residential schools.
6. That regional, residential-care institutions for the mentally retarded, who cannot be served in the community, be organized on a "cottage" plan, with careful control on maximum capacity; and that high-quality programs and services be developed in the cottage-type facilities with the goal of preparing as many of the mentally retarded as possible for return to life in the community.
7. That prompt action be taken to improve diagnostic and assessment facilities for the mentally retarded, through the establishment of regional, interdisciplinary, diagnostic clinics located at strategic population centers within Alberta, for purposes of prevention, early identification, parent counselling, public education, and the building of sound community programs.
8. That local associations for the mentally retarded be assisted, through Provincial Government grants for capital and operational costs, to establish sheltered workshops, activity centers, community residences, and farm training programs on a selective regional basis, for the purpose of developing community-based services which have been sadly neglected and are greatly needed. We consider the specific recommendations on "prevention and clinical facilities," to be found later in this submission, to deal with top priority needs.
9. That an interdepartmental, interagency committee, including representation from this Association, be appointed to study the legal and social status of the mentally retarded with the object of making recommendations for the modernization of provincial laws on mental retardation; and that the committee be empowered to consider multiple issues which go beyond those in Alberta's mental health regulations and current legislation.

10. That increased effort, planning and support, by both private and public agencies, be devoted to improving physical education, recreational opportunities and experience for the mentally retarded, who generally have limited access to physical, recreational and social activities.

Extent of the Mental Retardation Problem

One commonly accepted figure for the incidence of mental retardation in North America is three per cent of the population. On that basis Alberta's mentally retarded would number about 46,000. If borderline retardation were included, the number could be well over 100,000.

The Social Planning Council of Metropolitan Toronto, in 1961, estimated the extent of the problem as follows:

Estimated population, metro-Toronto, 1959:	1,500,000
Retarded (defective) - all ages:	45,000
Retarded (defective) - under 19:	14,000
Retarded (defective and borderline) - all ages:	144,000*
Retarded (defective and borderline) - under 19:	45,000

*This figure amounts to 9.7% with I.Q.s up to 79. The numbers of people in Toronto and Alberta are similar, so the above estimates provide some indication of the problem in Alberta.

The magnitude of the problem is accentuated by effects on the immediate family of a retardate. It is estimated that about two million persons, or one in ten Canadians, feel directly and personally the effects of this blight on human development. As Lyndon Johnson once stated, "mental retardation afflicts ten times more persons than diabetes, twenty times more than tuberculosis, and six hundred times more than polio." John F. Kennedy pointed out that every year 126,000 children are born (in U.S.A.), who will become mentally retarded. "This tragic human waste which, of course, not only affects the child, but the family which is involved, can and must be stopped."

Definition of the Problem

Mental retardation is incomplete mental development. Intellectual growth becomes impaired before, during, or after birth. The developmental period extends from conception through age sixteen. Because of impairment in adaptive behavior the individual is unable to meet the demands of his social environment as well as others do.

It is a condition distinguishable from mental or emotional illness in that the retarded person may be otherwise healthy and active and, within the limits of his intelligence, can be responsive to training and to social and moral responsibilities.

Classification and Terminology

The severity of mental retardation varies considerably. There is no one generally accepted classification system for mental retardation. The one in use in Alberta and Ontario will be cited now.

Category 1.

Mildly retarded or educable retarded (E.M.R.): persons with an I.Q. of 51 to 75, and mental ages from 8 to 12 years; generally capable of academic work, Grades 2 to 6; representing some 83% of the mentally retarded, or approximately 35,000 persons in Alberta. (Borderline retardation, representing a substantial additional number, is not included. Slow learners, of approximately 75-85 I.Q., also are not included.)

Category 2.

Moderately retarded or trainable retarded (T.M.R.): I.Q.s of from 25 to 50; when matured, with mental ages from 4 to 8; generally limited to rudimentary elementary school; representing about 13% of the mentally retarded, or approximately 6,000 persons in Alberta.

Category 3.

Severely retarded: I.Q.s from 0 to 24; mental ages from 0 to 4 when fully developed; capable, if at all, of mastering the simplest levels of self care and communication; entirely dependent upon others for their care; representing about 4% of the mentally retarded or approximately 2,000 persons in Alberta.

Present Facilities for the Mentally Retarded

1. Local Associations for Retarded Children

(Numbers are approximate.)

	<u>No. Served</u>
Calgary Association for Retarded Children	
Christine Meikle School	163
Emily Follensbee School	72
Pre-School and Day Nursery	25
Sheltered Workshop - Advance Industries	60
Camrose & District Association for Retarded Children	
Burgess School	19
Drumheller Association for Retarded Children	
Muriel E. Rowe School	3
Edmonton Association for Retarded Children	
Winnifred Stewart School	321

	<u>No. Served</u>
Grande Prairie & District Association for Retarded Children	
Peace School of Hope	52
Dormitory for Retarded Children (30 beds)	31
Cold Lake, Grand Centre & District Association for Retarded Children	
Class for Retarded Children (to open this fall)	10
Lethbridge & District Association for Retarded Children	
Dorothy Gooder School	51
Summer Camp (to begin this year)	30
Medicine Hat & District Association for Retarded Children	
George P. Vanier School	27
Summer Camp (to begin this year)	15
Red Deer Association for Retarded Children	
Parkland School	37
Strathcona (County) Association for Retarded Children	
Robin Hood School (includes some multiple handicapped)	28
(new school planned to accommodate approximately 50)	
St. Paul & District Association for Retarded Children	
St. Paul School (new school being built for 33 students)	15
Vegreville Association for Mentally Handicapped Children	
Dr. R. R. Cairns School	15
Vermilion Association for Retarded Children	
Vermilion School	8
Wetaskiwin & District Association for Retarded Children	
Wetaskiwin School (new school planned for 30 students)	19

2. The Crusade Projects

Centre for the Study of Mental Retardation - University of Alberta, Edmonton.

Industrial Research and Training Centre - Edmonton.

Vocational and Rehabilitation Research Institute - Calgary.

3. Alberta Government Facilities for Retarded

	<u>No. Served</u>
Alberta School Hospital, Red Deer, Alberta Age 6 - 16 (very low I.Q. to 75 approx.)	960
Baker Memorial Hospital, Calgary, Alberta (being enlarged) Age 0 - 16 (very low I.Q., multiple handicapped)	152
Deerhome, Red Deer, Alberta For adult retarded	1,360

4. Private Facilities for Retarded

There are also a few group homes, such as the Welwyn Manor in Wetaskiwin and the Mrs. Z. Gardner Home in Edmonton, which accommodate a small number of retarded children, perhaps fifty in all.

Critical Needs and Recommendations

In Alberta, we face a two-headed problem of providing facilities, programs and services to meet existing and past needs of the retarded; and also providing for increasing numbers in a growing general population. The needs to be specified here are all urgent.

Because treatment of mental retardation is multi-disciplinary in nature and affects a number of Government departments, they will be reported according to fields of service. This does not mean they should be dealt with in isolation; all concerned should actively cooperate and coordinate both in planning and in developing facilities and programs.

1. Research

Hopefully the answers to prevention, amelioration and treatment will come from research. Until recently little had been done in Canada. Much initial stimulation in the field came from the Psychiatric Research Institute for Children at London, Ontario, established in 1959 by the Ontario Department of Health. It works closely with the University of Western Ontario and has concentrated on fundamental medical and behavioral research. More recently the Canadian Association for Retarded Children initiated fourteen demonstration projects, a number of which are concerned with research. The three Alberta projects have important research functions. The Centre for the Study of Mental Retardation, University of Alberta, applies a multi-disciplinary approach to biomedical, psychological and educational research. The V.R.R.I. in Calgary conducts research on vocational skills, diagnosis and assessment, rehabilitation and basic studies. The Edmonton Industrial Research and Training Centre is involved in industrial research.

The Kinsmen National Institute for Mental Retardation, being developed for the Canadian Association for Retarded Children, will act as a gathering point for research information developed by the fourteen Crusade Projects and other sources.

Funding of these research projects has been difficult. Fortunately, the Provincial and Federal Governments have given substantial financial support for capital purposes and hopefully will continue to give strong support to on-going operations. Voluntary donations have also provided significant assistance.

This year the Alberta Association contributed \$4,100 to the Retardation Centre at the University of Alberta, and will give \$10,000 to V.R.R.I. in Calgary. These funds were raised by a special campaign undertaken last year.

Because of the broadening interest in retardation, some private organizations are taking an interest in research. For example, the Scottish Rite Charitable Foundation is contributing \$2,500 to a student doing postgraduate research studies at the University of Calgary. This is one of three of the Foundation's scholarships in Canada.

Some of the main research needs stated by the World Health Organization are:

1. Physiological and biochemical investigations into etiology and pathology; embryology; neuropathology and electrophysiology; genetics.
2. Investigations into emotional, social and educational aspects of etiology and pathology; individual and group psychotherapy; prevention of delinquency.
3. Methods of education, and of occupational and social training and guidance, which should ensure that full use could be made of remaining functions.
4. Prevalence studies of subnormality in different cultures and groups.
5. Continued revaluation of existing services in relation to community needs, and the integration and development of services.

Despite evidence of increased interest in medical and other basic research on mental retardation recently, much more is needed.

Intensive study by a variety of professions, working together, of causes, means of prevention, epidemiology, diagnosis, care, treatment, and education is essential.

Recommendations

1. Basic research into the causes and prevention of retardation is costly, so the Alberta Association recommends that all concerned Departments of Government increase their budgets for research.
2. Provincial universities should expand programs in mental retardation for students in education, psychology, medicine, nursing, social work and sociology; additional bursaries should be sought.
3. Increased Governmental support for the research programs in the three Crusade projects is recommended.
4. The Alberta Association and all local associations should include budget items for research.
5. The Canadian Association, through the Kinsmen National Institute for Mental Retardation, should develop a catalogue of research on retardation here and abroad. This information should be disseminated to all appropriate Government agencies, the Crusade Projects and the provincial associations for retarded children.

2. Organization of a Comprehensive Alberta Plan

The success of a provincial-wide program for combatting mental retardation must depend upon its administrative organization. The problems of the mentally retarded are of concern to many departments; solutions require a multiple and coordinated attack.

Recommendations

1. The Province of Alberta should establish an operationally independent Mental Retardation Board to study needs and develop comprehensive, co-ordinated policies and programs to meet those needs. (This recommendation would involve a significant change in Government policy, but our Association intends no criticism whatever of the Mental Health Division of the Department of Public Health. We need close liaison with the Mental Health Division of the Department of Public Health. However, the problems of mental illness and retardation, although in some ways similar, require programs which differ in origin and need. We recommend, therefore, that the Mental Retardation Program should have a separate identity from the Mental Health Program. There is an equal need for coordination and liaison with the other departments such as Education and Welfare.)

2. Detailed recommendations concerning the Board Follow:

a. Membership. It could include

The Director of Mental Health, or appointee

The Director of Special Education, or appointee

The Director of Vocational Education, or appointee

The Chairman of the A.A.R.C. Professional Advisory Council

A representative from each of the following: Department of Public Welfare, designated to be in charge of its mental retardation programs; Attorney General's Department; Department of Indian Affairs; Department of Labour; Department of Youth; Human Resources Development Authority; Alberta Association for Retarded Children; Canada Manpower; Centre for the Study of Mental Retardation, University of Alberta; Edmonton Industrial Research and Training Centre; Vocational and Rehabilitation Research Institute; and such other representatives as the Cabinet may propose.

b. Appointments.

Appointments to the Board should be made by the Cabinet and the Board itself should be responsible to Cabinet; non-government persons nominated for appointment should be proposed by their respective organizations.

c. Responsibilities.

(i) That the Board study immediately all programs for the retarded in Alberta and develop a comprehensive provincial-wide program to meet needs for facilities, programs and services; and that the Board on its own initiative recommend action to the various Departments and volunteer agencies regarding additional programming and revisions to services.

(ii) That the Board appoint its own officers and have power to appoint its own director, or coordinator and staff within the limits of funds.

(iii) That the Board develop a public information program to increase public awareness of the problem, its needs and what can be done about them; the program should include regional seminars on mental retardation.

(iv) That the Board submit reports, recommended by the Cabinet and the Board, to Departments and agencies working on mental retardation.

(v) That the Board form technical and special committees to implement its program.

(vi) That the Board develop a province-wide register of all mentally retarded individuals for professional dissemination of information on services and programs; such information should be made available to voluntary associations, to the three Crusade Projects and to appropriate Government departments.

(vii) That the Board develop a comprehensive program of gathering statistical information regarding the incidence and socio-economic factors involved in mental retardation.

(viii) That the Board develop a complete directory of programs and services available to mentally retarded within the Province, to be made available to doctors, welfare departments, health units, and parents.

(ix) That the Board recommend standards for programs offered by both Government and voluntary agencies.

(x) That the Board study all sources of Federal support and recommend the most appropriate use of funds to both Provincial Government and voluntary agencies.

d. Staff.

(i) It is recommended that the Board hire a coordinator or Executive Director to function under Board direction and:

1. Coordinate its activities.
2. Prepare reports.
3. Gather and disseminate information.
4. Maintain adequate records.
5. Hire and supervise staff.

(ii) It is recommended that the Board hire 2 or 3 specialists or consultants from the fields of medicine, education, psychology, genetics, social welfare, as these relate to mental retardation.

(iii) It is recommended that the Coordinator possess these qualifications:

1. A postgraduate degree in education, psychology, social work, medicine, etc. with specialized training and experience in the field of mental retardation.
2. Experience in community organization and volunteer work.
3. Experience and leadership ability in coordinated programming.

e. Regional Committees.

As the Board becomes established, it is recommended that its objectives be extended by regional committees comprised of health, education, welfare and a representative of the local Association for Retarded Children.

3. Home Care for Mentally Retarded

In a home care system a retardate lives either at home, in a foster home, or under temporary care in a community residence. It contrasts with putting the problem away in an institution. It takes account of community aid available to parents to help the retarded child make the best use of his potential. Retarded children in the trainable range generally fare far better at home than in large institutions, depending of course on a reasonably stable family situation and on the availability of training in the community. The program is both humanitarian and cost saving.

One study will be recorded in support. In a New York study of a representative sample of 520 retarded, I.Q.s 40-50, ages 17-40, who had been in special classes for severely retarded from 3-6 years and then were taken home, it was found that two-thirds were still living at home and 43% of them were getting along well with families. One-third of those living at home could venture away, take buses and subways and ask directions if they got lost. Other studies could be cited leading to the same general conclusion: institutions are poor substitutes for private homes and the relative freedom of community life. There are, however, children who will not be able to cope with their family or community situation and they will need referral to an institutional setting.

Parents require a diagnostic service to obtain a clear picture of their child's problem and of the level of development the child can be expected to achieve. Parents also need continuing guidance and access to other facilities if required.

About 95 per cent of all retardates can cope in the family environment, in foster homes or in community residences. Many can contribute to society. Those, who can cope with life in their community, progress better than those in institutions. They deserve the opportunity to live in their community, as do people with normal intelligence.

Recommendations

1. Initial counselling at mental retardation clinics should be followed by regular visits to the homes of retarded children by public health nurses, V.O.N. or social workers, who serve the community, to observe the child's progress and suggest care and training.
2. Adequate case records should be available to assure a continuum of guidance.
3. Training programs for public health nurses and social workers should include special courses in home care for retarded children.
4. Local associations for retarded children should consider hiring a public-health nurse or a medical social worker where the case load warrants.
5. Further evaluation of a child's progress should be assessed periodically at a clinic to determine further treatment.
6. Visiting workers should make every effort to identify developing cases of retardation and refer them to the clinics for assessment.
7. Visiting workers should become knowledgeable about other community services, such as recreational facilities, and endeavor to have the child referred to such facilities.

4. Pre-School Programs

If day care centers, day nurseries and kindergartens are needed for children of normal intelligence, this is doubly so for the retarded child. We know of no services of this type that take retarded children, particularly at the trainable retarded (TMR) level although mentally retarded children profit from such programs, particularly through development of motor and sensory skills, physical coordination and social adaptability.

Some of the schools for retarded children are already operating kindergartens. But there are no grants available for the programs. Other associations are considering the development of day care centers. Certainly the local associations for retarded children have the organizational experience to operate such programs.

Some working parents of retarded children have no place for their children during the day. Such centers would permit the family to keep the child at home, instead of placing him in an institution.

For economy, day care centers and kindergartens should be combined. Day centers for normal children cost between \$4.00 and \$5.00 per day per child and the cost for retarded children probably would be higher.

Recommendations

1. At least one local association for retarded children should develop a combined day center and kindergarten as a pilot project. The admission of children with other handicaps should be considered.
2. When one or two pilot projects have established their value to the retarded children, their families and community, other similar projects should be undertaken by other local associations in the larger centers of Alberta.
3. Government should support the centers as follows:
 - (a) An equipment grant up to \$4,000.
 - (b) The Department of Welfare or Education should support operations to the extent of at least \$840 per year for children under school age.
 - (c) Parents should pay 50¢ per day, minimum.

5. Training and Education

Schools for retarded children operated by the local associations for retarded children have proven that most children classed as T.M.R. can be trained. Some have progressed sufficiently to be promoted to opportunity classes in the regular school systems. A few have even gone on to establish themselves as independent in the community. The great majority have become able to cope with living with their family and in the community.

Our schools have taught the T.M.R. children to communicate, to coordinate physically, the basic requirements of adapting socially, crafts (some have become very adept), and even simple skills in reading, writing and arithmetic.

There are approximately 1,040 T.M.R. children and young adults in our schools and community programs. We are certain however that there are many more that we are not reaching. Identification has been a problem in that parents in some cases have been reluctant to bring their children forward. Others have been placed in opportunity classes, which is not the place for them. Placement of T.M.R. children in opportunity classes could well result in frustration and regression.

Referral has also been a problem in that some local associations for retarded children say that referrals of T.M.R. children are being made by Alberta Guidance Clinics for institutional care only. Some of the children referred in this way have been kept at home by their parents, placed in schools for retarded children, and have progressed quite favorably.

Identification and referral call for a coordinated approach on the part of all agencies concerned such as: health units, welfare departments, school divisions, guidance clinics, and the local associations for retarded children. A number of the children in schools for retarded are there largely because of the efforts of local associations.

Some rural areas of Alberta have retarded children but not in numbers large enough to develop a school. Daily transportation to the nearest school for retarded children is not practical. The answer to this problem is the development by local associations for retarded children of community residences for short term residential care of children from outlying areas. The only residential unit available now is operated by the Grande Prairie Association for Retarded Children. This unit has 30 beds; all are occupied and there is a waiting list. Undoubtedly with the development of community residences, more children would be able to attend one of the fifteen schools for retarded children in Alberta. This would tend too to give these schools a more regional character, and would permit the expansion of training facilities, program opportunities and better groupings according to potentiality.

The Alberta Association for Retarded Children contends that every retarded child in Alberta, either in the trainable or educable range, has the basic right of obtaining an education according to his ability. More opportunity classes and special vocational training facilities are certainly needed for E.M.R. children. The larger cities have progressed substantially in this direction, but a number of rural areas are lagging seriously.

Where special facilities and programs are not available, the problem is compounded, resulting in unskilled, frustrated drop-outs at 16 years, or earlier.

Early identification of retardation either at the E.M.R. or T.M.R. level is essential so that the child can be placed at his appropriate level of capability at the earliest age possible. As mental retardation

clinics become available, our Association believes that clinical assessments should be made mandatory for all suspected T.M.R. and E.M.R. children.

There is a known shortage of trained teachers. This is particularly true in the area of special education - both for teachers of opportunity classes, and for teachers at schools for retarded children.

There is also a shortage of classroom facilities for both groups. In the case of the schools for retarded children, there is a very serious gap between the total of \$8,000 per room available through the Department of Education and the actual cost. This gap ranges from \$25,000 at the St. Paul School to \$50,000 for the larger Robin Hood School being built for the Strathcona Association. These funds have to be raised from the community and from voluntary charitable sources, and represent approximately one third of the capital costs. The raising of such funds, especially in our smaller communities, is a difficult task. But the problem is compounded by the fact that these new schools require expensive equipment, such as woodwork shop equipment, household training appliances, gymnasium equipment, audio-visual aid equipment, looms, and craft materials; all are expensive. In addition, of course, furniture, books, and regular classroom supplies are required. No grants are available for equipment purposes.

In many states of U.S.A. and in some provinces of Canada (e.g. Ontario, Manitoba and Saskatchewan), most of the special schools for retarded children established through the efforts of local associations for retarded children have become a part of the regular school systems. It is the belief of the Alberta Association and most of the local associations, that all bodies concerned with the training of T.M.R. children should plan and work towards the integration of these schools into the regular school systems. This would involve the Provincial Department of Education, the local school divisions and the local associations for retarded children. The desire for integration stems from the belief that all retarded children deserve the same basic opportunity for public education as children of normal intelligence.

On November 20, 1959, the United Nations Assembly unanimously adopted and proclaimed a "Declaration of Rights of the Child." Set forth in the Declaration are ten principles covering "those rights and freedoms which the international community has agreed every child without exception whatsoever should enjoy." Quoted here is principle #7 relating to education:

"The child is entitled to receive education, which shall be free and compulsory, at least in the elementary stages. He shall be given an education which will promote his general culture, and enable him on the basis of equal opportunity to develop his abilities, his individual judgment, his sense of moral and social responsibility, and to become a useful member of society."

We earnestly submit that retarded children, both trainable and educable, have that right of developing their potentialities to the maximum through training, education and vocational preparation. Only those, who are severely retarded, or who are otherwise physically or emotionally unable to cope with life in their community, need institutionalization.

All concerned groups should plan for the integration of schools for retarded children into the regular school systems. Training and education at E.M.R. and T.M.R. levels should be mandatory; but a transitional period should be allowed for the provision of facilities, trained staff, and public information to inform all parents who are keeping their children at home, of the value and need for training. Manitoba, in 1967, legislated to require public schools to assume responsibility for the education and training of all retarded children including the T.M.R. children.

Planning for integration should include local associations for retarded children, as in Ontario, to retain the voluntary support and interest that has helped the schools for retarded children so much.

As schools become integrated, the associations could attend to other programs for the retarded which are seriously needed.

Recommendations

1. That the Department of Education conduct a provincial survey to determine the number of E.M.R. and T.M.R. children in each school division and thus enable the Department, local boards and associations to make long term plans.
2. That the Department continue to encourage the development of opportunity classes and other special vocational classes for E.M.R. children by local school boards.
3. That the Department work with local school boards and the nearest school for retarded children to encourage the referral of T.M.R. children to that school.
4. That the Department of Education review its scale of grants and encourage the development of additional classrooms for T.M.R. and E.M.R. children. Capital grants (T.M.R.) should be increased to \$9,500 per room. In addition, to cover the high cost of equipping these rooms, the Department of Education should consider an additional grant of up to \$1,500 per approved room.
5. To assist local school boards and the schools for retarded to develop improved facilities and programs, we recommend that the Special Education Division of the Department employ additional consultants with special qualifications in retardation to plan programs and facilities for all parts of Alberta.

6. In view of the shortage of qualified teachers for E.M.R. and T.M.R. children, we recommend that training programs for teachers of those children be expanded, be available on a short term basis (including summer, evening, or correspondence courses) and lead to acceptable certification. (The three Research Demonstration Projects will give impetus to the preparation of teachers and other staff.)

7. That fair recognition be given to experience and training of teachers of T.M.R. children, in admission to further training and in certification.

8. In view of the need for more teachers, additional bursaries should be provided to encourage prospective teachers and to assist present teachers improve their qualifications.

9. In view of the growing costs (\$1,000 to \$1,100 annually per child in schools for retarded children) and, because of the need to increase teacher salaries (which average at least \$2,000 per year less than regular school salaries), and because of the urgency of finding additional qualified teachers at competitive salaries, we recommend that the annual grant be raised from \$840 per child per year, to \$1,500.

10. In planning the integration of schools for retarded children into the regular system we recommend the Department consider the adoption of the Ontario system, in which Retarded Children's Education Authorities may be established. (Authorities administer the schools; 80% of operating costs are paid by the Provincial Government and 20% by the area council where the child resides. The program is supervised by the Special Schools and Services Branch of the Department of Education. Two members of the Authority are appointed by the local association for retarded and four members are appointed by the municipal council. A brief submitted by the Ontario Association for the Mentally Retarded in October 1965, to the Honorable Emmet M. Hall's committee on Aims and Objectives of Education, states:

"The plan of operation, unique in Ontario, has been accepted with enthusiasm resulting in an almost unbelievable smooth transfer from the Local Associations to the Authorities."

11. We recommend that the four members be appointed by the local school boards.

12. That a thorough review be made of curricula for T.M.R. and E.M.R. children, with emphasis on recreational and physical education as means of developing motor-perceptual, social, and group skills.

13. That Alberta develop a school-work training program, similar to Saskatchewan's, for E.M.R. and T.M.R. children.

14. Local schools for retarded children offer the only training available

for mentally retarded children in most areas, so they should also consider training children with associated handicaps who might profit.

Resolution on Teacher Certification

The following resolution was passed by the membership of the Alberta Association for Retarded Children at its Annual Meeting held in Red Deer, April 27 and 28, 1968:

WHEREAS over 120 teachers in Alberta are now engaged in teaching trainable retarded children in the various schools operated by our local associations and other similar bodies,

and

WHEREAS there is now "permissive" legislation, which would enable local public school authorities to assume responsibility for these schools for the trainable, but such action is hindered by the fact that the teachers, though many are experienced and highly competent, are for the most part not in possession of "Teachers' Certificates" recognized by the Department of Education and the Alberta Teachers' Association

and

WHEREAS the University of Alberta is now prepared to admit mature students, notwithstanding the fact that they may lack senior matriculation standing, provided they can show competence in their chosen field

and

WHEREAS the University of Alberta has instituted a Centre for the Study of Mental Retardation, involving several disciplines and has engaged highly qualified staff for the furtherance of this study.

BE IT RESOLVED that the Alberta Association for Retarded Children urge the Government of Alberta through the Department of Education; and the University of Alberta¹ through the

¹ I would note that similar developments have taken place at the University of Calgary: admission of mature students; recruitment of specialists in retardation by the Faculty of Education; and research and demonstration programs at the affiliated Vocational Research and Rehabilitation Institute. Thus resources for the preparation of teachers of trainable retarded children have been increased substantially since April 1968. W.R.N.B.

Faculty of Education, to offer a one-year course for the aforementioned teachers, which would lead to an acceptable certification. As an alternative to this, that summer school courses, evening classes or correspondence courses be developed, which would also lead to an acceptable certification.

It is further urged that the Government of Alberta should institute a system of grants which would enable a limited number of experienced teachers to undertake such training.

6. Institutional Facilities

Three public institutions in Alberta serve the mentally retarded and the Department of Health is to be commended for establishing them.

Although the institutions care for about 2,500 patients, we understand that all have long waiting lists. In 1967, the Alberta School Hospital, for example, was reported to have a waiting list of 500. Additional residential facilities are required for mentally retarded, who cannot cope with life in their community or profit from community programs. Further, mentally retarded persons, in institutions, who can be returned to the community, should be returned as soon as facilities are developed and thus make available space for those of greater need.

Recommendations

1. That additional custodial care institutions for severely retarded persons should be built apart from mental health institutions, but if possible near university centers.
2. That future institutions should be small units with a maximum capacity of 300 beds, organized on the cottage plan with small ward and training units.
3. That future public custodial care institutions should be located reasonably close to the families concerned. (A need for a smaller, regional institution in northern Alberta, near a general hospital, undoubtedly will develop.)

4. That all custodial care institutions provide social, recreational and occupational programs for all patients able to participate.

5. The ultimate objective should be to bring patients to the point of re-entering a community program, thus reducing the need for institutional accommodation. We shall continue, however, to press for institutional facilities for those in need.

7. Prevention and Clinical Facilities

Prevention

If we take the figure of 30,000 children being born in Alberta each year, we must expect to provide for close to 1,000 children who will be mentally retarded. Dr. Warren Stafford, former special assistant to the President on mental retardation has estimated that, "the toll of mental retardation could be reduced fully one-half if all we know today could be applied successfully everywhere ." If the program described in this paper could be fully applied in Alberta, we would reduce very substantially the number of "mentally retarded."

There is a most obvious and major need to undertake a concentrated, coordinated and multi-disciplinary attack on the causes of retardation. The need for research has been stressed above. Prevention involves not only bio-medical aspects, but also psychological, social-economic, and cultural. The new Centre for the Study of Mental Retardation at the University of Alberta, is following just that type of approach. In Calgary, the V.R.R.I. and the University of Calgary will contribute through their data retrieval and research center.

Prevention may take place from conception to birth, as well as the period shortly following birth. Bio-medical prevention, therefore, must focus on the prenatal, natal and postnatal periods.

Prevention is a primary aim in dealing with the problem of mental retardation, and essentially divides itself into two lines of action: (a) research to discover causes, (b) the prompt application of recently acquired knowledge. Examples of this would be the mass screening of the newborn for P.K.U., already being done in parts of the continent. This program requires only a drop of blood on a piece of filter paper taken just before the baby leaves the hospital to go home. The University Hospital, at Edmonton, has shown that, with one technician, serum phenylalanine levels could be measured on every newborn baby in the Province. Certainly such a program for the whole Province should be undertaken.

Another example is the prevention of RH sensitization, by giving the mother at risk an injection of anti-D gamma globulin. This is being done on a trial basis in Edmonton and Calgary, and it is hoped that this program

may be applied soon to all women at risk in the Province, thus preventing erythroblastosis (jaundice) in the newborn.

A third example is rubella. In recent months, it has been found possible to culture the virus for German measles. Hopefully it is only a short step to making a vaccine that would be given to all girls before they reach puberty.

Case Finding and Early Diagnosis

This is a matter of education of professional people and the public. Any young child whose development is not normal needs thorough examination to exclude deafness and blindness, and hopefully a definite diagnosis will be made before he reaches school age.

It would seem quite possible for local health units to carry out screening tests when a child reaches three or four and to pick out any delayed development, so that such cases could be more thoroughly examined. It is in this field that visiting consultants or child guidance personnel working in outlying areas would be most valuable.

Psychosocial Aspects of Mental Retardation

A complexity of biomedical factors may relate to predispose an individual to retarded functioning. In the final analysis, however, mental retardation is defined behaviorally, that is, in terms of intellectual, psychological and social deficits. A mentally handicapped individual is conspicuous primarily by his psychosocial incompetence.

The great majority of persons with subnormal intelligence, particularly the mildly mentally retarded, do not have identifiable physiological abnormalities. Presumably, there are familial-cultural-social influences interacting in intricate ways which depress the functioning of retarded persons in whom no organic deficit has been found. Further there is a great body of evidence that many of the retarded come from the lowest socioeconomic levels in our society.

This close relationship between adverse and abnormal environments and retardation demands intervention and correction. The indications are that much of the blight of mental retardation is closely linked to psychological and social deprivation. The evidence is strong for launching attacks on both the biological and the psychosocial fronts.

The social and psychological factors are of utmost importance in the prevention, care, treatment and education of individuals with mental retardation. There is an urgent need to apply what is known, and to extend research on the effects of environment on human development.

Clinical Facilities

The Guidance Clinics of Alberta have struggled gamely to help parents, teachers, and children to handle a great variety of behavioral, emotional and learning problems. The incidence of mental retardation has become so large and the need for in-depth diagnostic, assessment and treatment programs is so essential, that both our Alberta and local associations for retarded children believe that there should be a new, cooperative but specialized approach to meet the needs of the mentally retarded.

The importance of the earliest possible diagnosis has been stressed earlier. We cannot over-stress, however, the importance of the most complete diagnosis possible. This should include a full medical examination to determine if there are any hearing, visual, speech or coordinational problems which could lead to an erroneous assumption of retardation. Where convulsive disorders are found, there should be an opportunity for close observation; skull x-rays and E.E.G.s. There is a very real doubt that such detailed assessments can be made in outlying areas by travelling clinics because of the number of professional personnel required and the equipment needed.

It is essential, too, that a full battery of psychological and aptitude tests be undertaken so that wherever possible the assets of the retardate may be identified as well as his shortcomings.

We further believe that each child should be kept under observation at the clinic for whatever period is required to give the clinic staff an opportunity to see the child at play, his social adaptability, his physical coordination, etc. The clinic would then be better able to recommend a treatment program and refer the child to whatever community service is indicated. The treatment program can thus be a reasonably complete and comprehensive blending of recommendations from the medical, psychological, social and educational staff who have examined and watched the child over a period of time.

Because this assessment and treatment program could well represent the beginning of a life-time plan for that child, we sincerely believe that the diagnosis should be as complete as possible in order to establish an optimum treatment program.

Some children may be so seriously retarded or otherwise physiologically impaired that referral to a custodial institution may be recommended. We submit, however, that wherever a retarded child seems capable of coping with his family or community life, he should be referred to his nearest community or regional service, including the local schools for retarded children.

There should also be an opportunity for periodic re-assessment to determine progress and correction or change of treatment. This then would assure a continuum of assessment as part of the continuum of care.

The Alberta Association for Retarded Children holds, with substantial support from professional authorities, that a diagnosis of mental retardation should be tentative and subject to repeated review at regular intervals.

Recommendations

1. Our major recommendation is that two complete comprehensive diagnostic and assessment centres should be established for the mentally retarded at the earliest possible date within the coming five year period. One of these should be located in Edmonton. It could be operated in conjunction with the Glenrose Hospital or the new Medical Services Project at the University of Alberta. In either case, we would recommend that it be a part of, or at least work in close liaison with the Centre for the Study of Mental Retardation at the University of Alberta.

The second center should be located in Calgary. We would recommend that it be a part of, or work in close liaison with, the Vocational and Rehabilitation Research Institute which is being developed on the Campus of the University of Calgary.

2. We also recommend that at least two additional regional diagnostic and assessment centers be projected for early future development. One of these could be developed in conjunction with the new University of Lethbridge, and the other in the Peace River area. The latter could be developed in conjunction with the present Guidance Clinic in Grande Prairie, which within the limitations of its present facilities, has served the mentally retarded in the Peace River area very well.

3. Temporary hostels should be provided at each of these centers for the children and, if possible, for at least one parent, to provide an opportunity to give each child a complete multi-disciplinary diagnosis.

4. Such services should be covered under the provisions of the Alberta Health Plan, and other related hospitalization plans.

5. A diagnostic nursery should be established in conjunction with each center for temporary placement and observation of the child in a group situation.

6. All diagnostic and assessment centers should be equipped to provide a full range of clinical services including short-term treatment of acute illnesses of which retardation may be a by-product or sequel.

7. All staff in the diagnostic centers should be fully briefed on all services available within Alberta, so the most appropriate referral can be made to the local educational facilities, including the schools for retarded children. Full referral information, along with the treatment program should be passed to the local school or community service involved.

8. All training programs for professional personnel, including doctors, dentists, nurses, public health personnel, social workers, guidance counsellors, teachers, etc. should include instruction appropriate for their profession in diagnosis, treatment, counselling and referral.
9. The Department of Health in conjunction with the nearest University and local associations for retarded children should cooperate to sponsor regional seminars on retardation, such as the very successful one held in Lethbridge early this year, for public health nurses, social workers, teachers, and parents.
10. The Mental Retardation Board, in coordination with the various Government agencies concerned and the Alberta Association for Retarded Children, should sponsor continuing public educational programs on mental retardation.
11. All infants born prematurely should be referred to the local public health nurses for follow-up.
12. The nursing programs of health units and the V.O.N. should be expanded to enable them to give continuity of guidance to parents and their retarded children.
13. Special medical attention should be given to mothers in the "high risk" groups in order to provide early preventive measures.
14. The Alberta Department of Public Health should develop and support programs restricting the use of potential teratogenic drugs and radiation during pregnancy.
15. The Department of Health and the local health units should continue to strengthen their programs of immunization against measles and other communicable diseases.
16. The Alberta Department of Health in conjunction with the Department of Education, the Mental Retardation Board, the Alberta and Local Associations for Retarded Children and the Alberta Dental Association should include in their programs good health and dental training information for the mentally retarded.
17. The Department of Public Health should expand the program of assuring that every new born baby in Alberta hospitals will receive blood and urine tests for early detection of conditions associated with retardation.

8. Community Services

Throughout the text of this brief there is a basic tenet that, wherever a retarded person is able to live with his family or in his community, he should have both the opportunity and the right to be so located.

This objective applies particularly to the usual ambulatory retardates in the trainable and educable range, who do not have other serious physiological, emotional or convulsive disorders requiring almost constant professional care. The great majority of the mentally retarded (from 90 to 95 per cent) are capable of remaining in their community and of contributing to that community.

It is our view that some will be able to be habilitated to the extent that they can live a relatively independent life with the family and in the community. Others will require guidance and at least the opportunity for a sheltered environment with some financial support.

There are seventeen local associations for retarded children in Alberta. Others are needed and are being developed. It is our firm belief that these local associations are in the ideal position of being able to plan, organize and develop facilities locally or, where the population is dispersed, on a regional basis, with perhaps several local associations working in cooperation. We say this because:

1. These are the only organized groups throughout the Province who have had the knowledge and experience necessary to organize and set up such facilities in the community. The local associations have been operating 14 schools for retarded children with more in prospect. As the schools become integrated into the regular school system, these local associations will have more time and opportunity to concentrate upon the development of new and direly needed facilities.
2. These local associations have a good basic and practical understanding of mental retardation and its needs.
3. They have the dedication and the volunteer leadership to establish these facilities, and the volunteer manpower to make them function effectively, and economically.
4. By making use of other community services already largely in existence such as the local health units, local offices of social welfare, local recreational facilities, etc. there would be little needed by way of additional supportive services.
5. Such facilities would enable the mentally retarded to remain with their families, or in the community, thereby meeting the objective generally recommended by leading experts in the field of retardation today.
6. Such facilities would decrease the burden placed upon existing institutions operated by Government and would obviate the necessity of building additional large and expensive facilities.

7. They would also make possible the transfer of both capital and operating funds from large projected new institutions to support community oriented services.

8. Because of the volunteer funds that will be funnelled into such services, and by making use of both local volunteer workers and existing community services, we firmly believe, that the local associations can operate these services more economically. If it costs the Government an average of \$2,500 or more a year to maintain a mentally retarded person in an institution, we submit that this money can be spent in the community more effectively both on humanitarian and economic grounds.

9. By establishing community facilities there will be a two-way advantage of having the mentally retarded participate as individuals in community activities and residents within the community can become familiar with retardation and help with community programs.

Earlier in this brief we emphasized the need for pre-school programs such as day centers and kindergartens. These community centered programs are most essential for the age group living at home.

In this section of the presentation, we are referring to programs needed for (1) school age children and (2) late adolescent and adult retardates. From a recent questionnaire distributed to the local associations for retarded children, we have ascertained the most urgent needs for this age group. Because information represented the views of some 1,500 members, parents and teachers from the local associations, we can only conclude that their recommendations represent a province-wide census of needs. The needs are immediate.

We also sought to ascertain the priority of the needs and found the following two programs received almost equal support, from most of the local associations, as top priority needs:

1. Sheltered workshops and activity centers
2. Community residences.

A third community need, which should really be considered regional in concept is a farm training program. Because of the limitations of our climate, a combined farm training and sheltered workshop activity would be necessary to keep trainees occupied throughout the year.

Sheltered Workshops and Activity Programs

There are now over 100 sheltered workshops being operated by associations for retarded children in Canada, over 50% of community workshops being operated in Canada by volunteer organizations. We operate only one sheltered workshop in Alberta, Advance Industries in Calgary.

There is a clear need for additional sheltered workshops immediately for late teenage and young adult retarded persons who have finished school or who are still in a school for retarded children with no other place to go. Very few of this group require institutionalization.

The basic role of a sheltered workshop is to help each mentally retarded person develop as fully as possible. The development and maintenance of the dignity and self-worth of the individual are inherent in this type of service. The ultimate hope is to train the retardate to the point where he may find outside employment and make his own way. This is possible for a number of the mentally retarded of the educable group who have not been able to make their way through the regular school system and special vocational education classes. Even a few of the T.M.R. group may, through training, vocational guidance, and understanding employers, also make their way independently in the community. Some 29 have done so in Calgary; three of these were T.M.R., the others of E.M.R. levels.

The majority of the T.M.R. group will stay in the workshop where, in a sheltered environment, they can often produce surprisingly well, thereby achieving both self-satisfaction and a place in the community.

The main difference between retardates in sheltered workshops and those in adult activity centers is that the former would be able to participate in a substantial work day in a satisfying way; the latter would have more modest productive ability and a limited work span, and would be able to do only very simple work requiring limited skills and production. Nevertheless some individuals in the latter group, with I.Q. levels lower than 25, can remain relatively happy individuals in the community. The activity centers can function as part of a sheltered workshop program.

Sheltered workshops serve as an excellent vehicle of pretraining for the two Crusade Projects in Edmonton and Calgary or for post-placement after training, for those who do not find outside employment as a result of such training.

The sheltered workshop is not only an integral and essential community service serving a large segment of handicapped persons. It also performs a role in the business life of the community, since it undertakes contracts for services to the community, often engages in manufacturing or assembling of products, and trains workers. It also calls on the community for financial support, purchase of services and products, and for job opportunities for their trainees.

Some five or six sheltered workshops should be developed as soon as possible within the coming five years. While the primary objective is to serve the mentally retarded, since they compose the largest group of chronic handicapped people, nevertheless we feel there is also an obligation for sheltered workshops to serve other handicapped groups as facilities permit.

We believe that the facilities are needed most urgently at: Grande Prairie, Camrose, St. Paul, Wetaskiwin, Vegreville, Cold Lake, Medicine Hat, Red Deer (combination farm training and sheltered workshop), Strathcona and Vermilion. Some of these areas are so located that the workshops could be regional in form and be able to service a combined area.

A very similar approach is indicated for planning, developing and financing sheltered workshops and farm training centers; so our recommendations will present one solution for both.

Community Residences

Community residences make it possible for the mentally retarded to live in or near their own family and community. They also afford the first opportunity for retarded children to experience living away from home in a secure and sheltered environment but also close to their families.

A community residence is not an institution or a hospital, but a home which permits retarded persons to circulate and become part of a community. It has a paid staff that serves in the capacity of parents to a group of 8 to 12 children or adults. It is generally agreed that these residences should blend into the community and become another home in a neighborhood. They may be built as new homes geared to the needs of the group or be developed as renovated homes. The community residence has a strong family orientation with emphasis on the individual. They should not have more than 15 residents because there is a danger of becoming a small institution. As additional facilities are needed, more residences should be obtained.

The community residences would not replace the Alberta School Hospital or Deerhome, or additional custodial care institutions. It is hoped, however, that the development of community residences will leave no need to increase the size of the two institutions. It could then be possible to reduce their numbers. The community residences are intended to complement such institutions as the Alberta School Hospital and Deerhome and to relieve crowding and long waiting lists at those institutions.

Community residences typically function in a non-professional or non-clinical role for mentally retarded persons who do not require institutionalization. Their staffing, too, is often non-professional. Generally a home is staffed by a couple, who have a suite of their own and are assisted by a cook and part-time help as required. Frequently the house mother does the cooking. There should always be a training component built into the program at a residence so each resident will develop socially and have some role in the operation and maintenance of the home. Typically, the ratio of staff to residents is one to three. The choice of house parents is of prime importance. All supervisors, and the residence committee responsible for planning and administering the residence for the local association, should have some previous orientation and training.

In regard to the planning, organization and setting of admission policies, standards of service, etc., the Alberta and the Local Associations for Retarded Children would welcome guidance from the Department of Welfare, under whom we understand such homes would come from a jurisdictional standpoint. Advice from other Provincial departments and local authorities would also be welcome. In the interests of economy and of developing adequate buildings, we would hope that the experience of Government officials in the design of new facilities, or the renovation of existing homes, could be utilized.

The Need for Community Residences

Community residences for the retarded are already established in several provinces such as Ontario, New Brunswick and Manitoba. In Ontario, we understand that nearly 30 community residences are being planned or built. The need for them can be dealt with by age-groupings: children; and late teenagers and adults.

a. Children

1. There is a very urgent need for residential facilities for children attending the schools for retarded children, particularly those from outlying areas. There are children who should be attending our schools who are either unable to do so or find it very difficult because of distance. The local associations have endeavoured to find foster homes, but increasingly this is becoming more and more difficult. Such homes would, of course, be available for the use of children attending the schools when integration with the regular school system is effected. We are certain that a substantial number of additional children would be served by our schools if residential facilities were available.
2. Because of the illness of parents, socio-economic factors and other reasons, there are some retarded children who are not being cared for adequately at home.
3. There are frequent cases of children who live quite happily and successfully at home but who need temporary placement in the community and near the local school while parents are away from home. We would hope that each community residence would be able to accommodate one or two children on a temporary basis, to provide respite for parents.
4. At present, apart from the dormitory operated by the Grande Prairie Association, and limited foster home care, there is virtually no accommodation available for retarded children who do not require institutionalization. The community residence offers the means of providing residential facilities in the community, and near the family. It also provides a means of caring for children, who are on the waiting list of the Alberta School Hospital and of alleviating the need for building institutional facilities for those able to cope with community life.

5. Community residences can serve as half-way houses for children who are being rehabilitated from the Alberta School Hospital back to community life.

Placement in community residences for children could therefore be temporary, short term or for the duration of their school program.

b. Adult

Much of the text of this brief has dealt with the needs of retarded children. Now we are facing a situation where many in the schools for retarded children are reaching or have already reached late teenage or adult life. Apart from one workshop, Advance Industries in Calgary, and the two developing Crusade Projects in Calgary and Edmonton, we have little to offer the adult retardate. We have proposed the development of some six sheltered workshops, but we have not dealt with the matter of residential care in the community for these people.

There is definitely a place in the community, for those able to adapt themselves to it, without the current necessity of having to institutionalize them.

Short term placement is needed for those confronted with family pressures, temporary disruption of the home, sickness in the family, etc. Short term placement is also required for those who need a half-way house after release from an institution back to community life. It is needed for those in job training at the Crusade Projects or at sheltered workshops. Long term, perhaps even terminal placement, will be needed for those adult retarded persons who have lost their family or who have none. Placement for adult retardates will be particularly needed to complement and make possible the development of the sheltered workshops, especially for those living away from their family. The same situation would apply to those participating in a farm training program.

Farm Training Program

A comprehensive program for the mentally retarded would require the provision of farm training. The purpose would be to train the late teenage and adult retarded for placement either as full time or part time farm employees. A second purpose would be to develop activities on the site, such as green house culture, truck gardening and nursery work that would produce food and revenue. This would provide useful employment for those retarded who adapt themselves better to a farm setting.

Because of our climate the farm training program would likely have to be supplemented by a sheltered workshop or activity program in winter.

There are two local associations in Alberta, which are interested and willing to undertake such projects. These are the Lethbridge, and the Red Deer Associations for Retarded Children. Both are well situated to undertake these programs.

Recommendations

Sheltered Workshops, Activity Programs, and Farm Training Programs

Because these programs are similar in concept and purpose, we are grouping our recommendations to cover all. We are also submitting these recommendations on behalf of the local associations for retarded children so that, from an organizational, administrative and funding standpoint, there will be a common approach to Government support. Each local association or regional groups of associations would be prepared to plan and develop the facilities, provide volunteer leadership, volunteer help and voluntary financial support from the community.

1. We recommend that immediate planning be undertaken by local associations for retarded children to establish some five or six sheltered workshops at: Grande Prairie, Camrose, St. Paul, Wetaskiwin, Vegreville, Cold Lake, Medicine Hat, Red Deer (combination farm training and sheltered workshop), Strathcona and Vermilion. These could be regionalized, as practical.
2. A farm training project should be established as soon as possible in the Lethbridge area for the Lethbridge and Foothills Associations.
3. Sheltered workshops and farm training programs should be prepared to accept other handicapped persons as facilities permit.

4. Capital Funding

In the case of sheltered workshops, we would recommend that, wherever possible, for the first two years, or until the programs become established, rented or leased facilities be used. We recommend that the Government of Alberta assist in the establishment of the sheltered workshops up to \$10,000 each, to cover the refurbishing and the equipping of approved centers by local associations that are affiliated with the Alberta Association for Retarded Children; or make a grant of 80% of the cost of building new approved facilities; and that the Government of Alberta make available a grant of 80% of the cost of approved equipment for the facilities. We would also recommend that similar grants be available to the proposed farm training centers or combinations of farm training centers and sheltered workshops.

After the development of the first one or two workshops we would recommend that these amounts be reviewed.

5. Operational Funding

It is necessary to consider trainees, who are being trained and prepared for job placement; others who are capable of performing regularly and productively in the sheltered workshop environment; and persons capable of only limited productivity in an activity center.

Our recommendation is that the Government of Alberta consider the payment of \$8.00 per trainee day to assist in the operational costs of each local or regional sheltered workshop and farm training program, during the first year of operations, and that this allocation be reviewed at the end of each succeeding year. It is further recommended that, in the case of those retarded persons who are not suited for permanent outside employment, a per diem grant of \$4.00 be allocated by the Government of Alberta, subject to a review of actual costs.

6. It is further recommended that as these sheltered workshops become organized, viable centers, additional facilities be planned for other areas of Alberta still unserved, according to their demonstrated needs.

7. The Provincial Department of Public Welfare should pay the full per diem costs of any individuals or families on social welfare.

8. Each local association or group of associations developing such a project, should appoint a special sheltered workshop committee, that would be representative of all local associations involved, but would be responsible to the board of the local association where the workshop or farm training center would be located. This committee would be responsible for planning and developing the facilities, for admission policies, programs of work, staffing and maintenance of good standards of service, etc.

9. Key members of the committee and of the staff should take special training and orientation programs such as those conducted by the Canadian Association for Retarded Children. Regular additional training should be taken by the staff of the workshops. It is hoped that the two Crusade Projects, the V.R.R.I. and the Edmonton Industrial Research and Training Centre could be used for this purpose.

10. The committee should seek out members with special knowledge in the areas of contract procurement, business management, program development, personnel matters, as well as representatives from community organizations, public health and welfare officials.

11. Regular financial records should be kept of all purchases, expenditures and revenues involved in the projects.

12. Adequate case records, regular progress reports of each trainee, should be maintained and be available to Government officials as needed and to the board or boards of the local associations involved.

13. The Alberta Association should endeavour to assist in the planning and development of each of the projects and to work in liaison with them, the appropriate Government officials and the Crusade Projects.

Community Residences

Recommendations

1. Because of an urgent need for community residences for retarded children, located near the local schools for retarded children, and in view of a similar need for residences in conjunction with the proposed sheltered workshops and farm training projects, it is recommended that planning begin immediately on the development of:

- Six (or more) community residences for children
- Four (or more) community residences for adults.

2. We recommend that the residences be developed and administered by local associations for retarded children (or regional combinations of the associations).

3. It is recommended that a coordinated, comprehensive plan be developed covering such essentials as:

- a. Structure of local residence committee
- b. Management policies
- c. Essential physical facilities
- d. Admission procedures
- e. Staffing
- f. Program and standards of service
- g. Financial support.

4. The Department of Welfare should consider a plan of financial support to be available to each local association where there is a demonstrated need for facilities.

(In Ontario a 1962-63 Act regarding homes for retarded children explains "home for retarded children" means a building maintained and operated by an approved local Association for the residential accommodation of retarded children ..." and further, "Local Association" means a parents' group that is affiliated with the Ontario Association for Retarded Children and is in receipt of assistance for the cost of education of retarded children under the Department of Education." This original Act grants \$2,500 per bed for the construction of new buildings or an amount equal to 50% of the cost, whichever was less. For approved existing buildings an amount of \$750 per bed or 50% of the cost was granted, whichever was less.

This same Act also provided an amount of 50% of the net operational and maintenance costs to the local association for approved homes.

In 1966 this Act was replaced to extend support for residential care for retarded persons at any age, \$5,000 per bed for new construction; and \$1,200 per bed for renovation. The operating grant is now 80% and is based on the immediate past three months for private placements. Parents pay according to ability. In the case of Government wards, the full per diem cost is covered. The balance is paid by the local association. We understand too, that the Province of New Brunswick now pays \$5.00 per diem in support of operational costs.

A number of local associations in Ontario, approximately 30, have built or are planning residences. We understand too, that the actual building costs for new facilities have reached \$6,000 and more per bed.)

5. For Alberta we would recommend that the Provincial Department of Public Welfare consider a financial support program to local associations who are affiliated with the Alberta Association for Retarded Children as follows:

- a. A capital grant for approved new construction of \$4,000 per bed, including the beds required for staff in residence.
- b. An equipment grant of \$500 per bed to cover approved costs of furniture, kitchen, laundry and recreational equipment.
- c. A capital grant of \$2,000 per bed for purchase of approved existing buildings and property.
- d. An equipment grant of \$500 per bed for existing buildings.
- e. An operating and maintenance grant of 80% of the total per diem costs.
- f. That the full per diem costs of any government or municipal wards be granted.
- g. That the parents pay according to ability.
- h. That the local association for retarded children pay the balance of the operating and maintenance costs.

Note: If one estimates the current capital cost per bed of a hospital training school to be a minimum of \$10,000, it will be seen that community residences can be built at much lower cost to the tax payer. We also believe that the Local Association for Retarded Children can operate them more economically.

6. We recommend that a special community residence committee be established for each home, responsible to the board of directors and that its membership include such representatives as public health nurses, social workers, teachers, medical personnel, businessmen and community leaders.

7. Regular financial records should be maintained setting forth receipts and expenditures and these should be available to Government officials and the Board as required.

8. Case records and progress reports should be maintained for each resident.

9. Legal Status of the Mentally Retarded

Society has undergone a marked change in its outlook towards the whole problem of mental retardation. As a result, any comprehensive plan for meeting the whole problem, and the tremendous needs of this substantial segment of our population should also make a careful study of all the legal provisions affecting the mentally retarded, their families, foster parents, guardianship, etc.

To our knowledge, there are very few statutes, if any, that are written to protect the mentally retarded or their families against victimization.

If there had been time this Association would have set up a legal committee to go into the various aspects of the present legal position of the mentally retarded and to make appropriate recommendations. This, however, is a specialized task which would require a study in depth. With the growing understanding of mental retardation, its needs and the developing programs to meet those needs, the time has arrived for a complete study of our current laws or lack of them, and to make recommendations of new regulations covering the needs of the mentally retarded in Alberta.

Recommendations

1. That a legal committee or commission be set up at an early date to look into all aspects of the regulations and laws covering the mentally retarded.
2. That this committee consist of representatives from the Attorney General's Department, the Departments of Health, Welfare, and Education, the Faculty of Law from the University of Alberta, and the Alberta Association for Retarded Children.
3. That this committee examine and recommend a legal definition of mental retardation, and the various terms used regarding it, in modern terminology.
4. That the committee consider the laws and regulations covering mental retardation in other parts of Canada and elsewhere.
5. That the committee take into account the recommendations of a study which we understand is currently being undertaken by the Canadian Association for Retarded Children.
6. That the committee make recommendations regarding (a) the effectiveness of current laws and (b) new regulations that it deems necessary for an adequate legal status and protection of the mentally retarded.
7. That these recommendations cover such aspects as: guardianship, placement, commitment, adoption, legal action, marriage, physical abuse,

sexual offences, juvenile courts, inheritance, delinquency, sterilization, abortion, the legal responsibilities of institutions, schools for the retarded, community residences, day centers, etc.

10. Physical Education - Socio - Recreation Programs

In recent years physical training and recreation have become recognized as essential parts of comprehensive programming for the retarded. Both contribute to the development of motor skills and physical coordination which are so important particularly to the more severely retarded person. Such programs have a place in the home, are needed in the schools and should carry on throughout adult life.

Of the 14 schools for retarded children in operation, 8 have adequate gymnasiums for physical training and recreation, and undertake regular physical training programs. Some of these are becoming quite sophisticated. Three new schools are being built or planned and will be able to conduct programs of this type.

During the past year an active Centennial Athletic Program was developed through the auspices of the Canadian Association for Retarded Children. This program tended to spark a variety of athletic activities and competitions. Most of the schools in Alberta participated.

Last summer a special physical education workshop for teachers of T.M.R. children was undertaken with the support of the Canadian Association for Retarded Children and the Alberta Department of Youth. It was planned and carried through by the University of Alberta, (Faculties of Education and Department of Extension) and the Alberta Association for Retarded Children. Much credit for this goes to Dr. P. L. Austin of the University of Alberta.

In late May of this year, through a similar cooperative effort of the Alberta Department of Youth, the Canadian Red Cross Society, the Lethbridge Recreation Department and the Alberta Association for Retarded Children, a water safety workshop, was started in Lethbridge to train volunteer leaders and staff how to organize water training programs in some twelve communities of Alberta.

Three or four local associations for retarded children are undertaking summer camp programs for the first time this year.

Progress has been rapid in this field during the past year or two. But much more emphasis is needed on vigorous activity, both by way of physical training and recreation to develop the motor skills and coordination of our retarded children and adults.

Tests conducted on retarded children have indicated that they have only one-half the strength of the equivalent age group of normal children, and

their endurance is 30% less than normal children of the same age. Research indicates that both boys and girls who are mentally retarded tend to be seriously overweight. In regard to motor skills, retarded children tend to run 2 to 4 years behind normal children in simple physical tests for children of school age.

A prime need in the field is one of leadership development and staff training to plan and develop both the physical training and recreational programs for both retarded children and adults in the schools, the institutions, community residences, sheltered workshops, and for leisure time activities in the community.

The adult retardate should not be forgotten. Almost without exception, he has lacked sufficient opportunities for personal and social development. Some retarded teenagers do not remain active and lose skills they had in childhood. Some do not associate with a variety of people after leaving school and become withdrawn.

Physical education is essential to the development of motor skills in the school. Recreation, in and out of school, and during the summer months, plays a major role in helping the mentally retarded attain social development and skills. Such programs as dancing, bowling, skating, gymnastics, swimming, skiing, etc. have a dual role of helping the mentally retarded to make good use of what motor skills they have, and also of giving them an opportunity to mingle with their peers in the community wherever possible.

Recommendations

1. That recreational programs and physical exercises become a part of the early home training program.
2. That schools for retarded children plan to devote a regular and substantial portion of their curriculum content to physical education and organized recreational programs.
3. That all community groups such as local recreation departments, the Y.M.C.A., Y.W.C.A., Boy Scouts, Girl Guides, and church organizations be encouraged to develop programs in which the mentally retarded can participate.
4. That the Faculties of Physical Education (as has been done at the University of Alberta) continue their efforts to develop special training programs for the mentally retarded.
5. That the Alberta Department of Youth continue and expand its efforts to train leaders and staff in organizing recreational programs for the mentally retarded particularly during the summer months when the schools are closed.

6. That the present efforts to develop water training programs for the retarded be continued and expanded.

7. That the initial efforts being undertaken this year to establish summer camping programs be expanded so facilities may become available for longer camping periods and much greater participation. There are a number of camps already in existence in Alberta, which have facilities that are not being fully used. It is not our intention at this time to urge the purchase and development of large camp facilities for the use of retarded only. It is our recommendation, however, that existing facilities be expanded regionally so that special camps for the retarded will be in a position to serve both children and adult retardates in larger numbers and over a longer period.

Acknowledgements

The Alberta Association for Retarded Children wishes to acknowledge with deep thanks the assistance it has received from professional people such as psychologists, doctors, educationists, teachers and others who have contributed to the content of the foregoing brief.

We are most appreciative, too, for the information given by the Local Associations for Retarded Children, and for that contributed by numerous parents and others experienced in the field of mental retardation, and in community programming.

In particular, we wish to express our appreciation for the guidance given by the following:

Dr. Patricia L. Austin, University of Alberta
Dr. Donald R. Cameron, University of Alberta
Dr. David Gibson, University of Calgary
Dr. J. Kenneth Martin, University Hospital, Edmonton.

In addition, we are indeed indebted to many sources of reference. The information gathered from various briefs, reports, booklets and books, represents a very broad cross-section of findings and recommendations from studies conducted across Canada and United States.

CHAPTER 11

THE CANADIAN MENTAL HEALTH ASSOCIATION

ALBERTA DIVISION

CMHA Statement of Purpose and Objectives....

"The purpose and objectives of the Association shall be to ensure the best possible care, treatment and rehabilitation of the mentally ill and the mentally disabled; to strive to prevent mental illness and mental disability; to promote research into their causes, treatment, and prevention; to protect and promote mental health and in the execution of the foregoing to secure the support of the public and to cooperate with other agencies and associations both professional and lay, working in these and related fields, and to urge governments at all levels to take legislative and financial action to further these objectives."

Preamble

The Canadian Mental Health Association, as a community organization, presents these considerations to the Alberta Mental Health Study.

The ideas and recommendations contained herein represent an attempt to provide to the "consumer," or citizen, the best possible array and quality of services within the limits of available funds, staff, and other resources. As William Ryan, Ph.D., stated (1967) "... this purpose is very simple: to solve the problems that impede effective and efficient services for emotionally disturbed persons. It is not to construct an elaborate blueprint, either for the location of buildings, or for the imposition of favourite techniques and sanctified programs." (Canada's Mental Health, November-December 1967)

With this presentation the underlying and imperative principles will be:

"Mental illness should be dealt with in the same organizational framework as physical illness." (More for the Mind, CMHA, 1963)

"That henceforth all the discriminations in the distinction between physical and mental illness in the organization and provision of services for their treatment, and the attitudes upon which these discriminations are based be disavowed for all time as unworthy and unscientific." (Royal Commission on Health Services, 1964)

To develop programs in keeping with these principles, five ingredients (recommendations) are essential:

Integration - mental health services should be integrated with physical and personnel services of the rest of services provided for people.

Regionalization - mental health services should be established in centers of population on a regional basis and a wide range of mental health services be established in larger communities.

Decentralization - management and administration of psychiatric services be decentralized.

Continuity of Care - close cooperation among treatment personnel and coordination of psychiatric services be maintained to ensure that the troubled person receives appropriate help in his community through all phases of his illness without interruption.

Coordination - local mental health services be coordinated to promote maximum effectiveness.

The main concerns of this submission will relate to the diagnosis, treatment, and rehabilitation of the mentally ill. Some attention will be devoted to primary prevention, but this, as yet, is an area where insufficient "hard" knowledge exists to propose any firm programs. CMHA will apply the preceding recommendations as they relate to the major sections of this brief:

1. Administration and organization
2. Community or regional facilities
3. Manpower - utilization and development.

An additional section, Emotionally Disturbed Children, is included because of specific concern in this area.

If appropriate consideration leading to implementation is given to these major areas, the prime requirements in an adequate program of treatment and rehabilitation of mental health problems will be served.

CMHA wishes to make clear that, while we refer in the brief to mental health services, it is the Association's firm opinion that integration of these services within the framework of general health services is extremely important.

One of the main themes contained in this presentation is the reiteration of the concern for involvement in the broadest possible terms. CMHA, because of its community identification and its role as a citizens' organization, believes that communities and the citizens in them are ready to play a far more significant role in developing and maintaining their own mental health services. Therefore, it is suggested that a method of developing mental health services, which involves federal, provincial,

municipal, and private financing, and which allows the individual citizen a significant role in operation and administration of mental health services, should be a desirable and achievable goal. The present method of operating mental health services does not allow such participation, and has resulted in a general disregard on the part of the public to the state of mental health services.

1. Mental health services should be handily available to any resident of the Province requiring them. At the present time this is not the case.
2. There is yet no general inclusion of treatment for mental illness in the overall medical services of the Province. Health units, most general hospitals, and other medical services have not yet consciously included and provided mental health services on a par with those for other types of illness.
3. There is an extremely critical shortage of personnel in the mental health services operated by the Department of Public Health.
4. Rehabilitation programs for the mentally ill are inadequately developed to meet the needs of the patient who has had treatment and is ready to attempt readjustment.
5. Services for emotionally disturbed children and adolescents, although they exist, are not integrated, nor do they seem to have been planned to effect the best possible use of professional resources.
6. It appears that development of mental health services has not been planned or developed in keeping with the patterns for planning and developing other types of health services.
7. Broad professional collaboration has not been present in developing solutions to manpower requirements and service developments.
8. Isolation, professionally and geographically, has been characteristic of Alberta's mental health services.

CMHA will devote attention to these various aspects in the following brief by suggesting approaches which should lead to a high calibre of mental health service. Without question the improvements will be costly initially but programs of rehabilitation, more intensive treatment and earlier intervention have been proven far more economical in the final analysis. People are less disabled by prolonged illness and therefore contribute more to the general economy and are less a drain on welfare and

health resources when treatment approaches are comprehensive and intensive.

In the following sections of this brief there may appear to be some duplication and repetition, but this is due to the close relationship each of the areas has to the others in complete mental health services.

Administration and Organization of Mental Health Services

Royal Commission on Health Services, 1964:

"That henceforth all the discriminations in the distinction between physical and mental illness in the organization and provision of services for their treatment and the attitudes upon which these discriminations are based be disavowed for all time as unworthy and unscientific."

Recommendations

1. There be developed a "delivery system" of mental health services on a regional basis which allows the mentally ill individual to be treated in his home community, or within a 75-mile radius.
2. Place mental hospitals under the hospital insurance and diagnostic services act, and establish boards for the administration of each mental hospital.
3. Establish an independent Provincial Mental Health Commission advisory to the Health Department.
4. Establish Regional Mental Health Boards which should have representation on the Provincial Mental Health Commission.
5. Establish interdisciplinary professional advisory committee to the Mental Health Commission.

Integration

Administration and organization of mental health services within the Department of Public Health are isolated and separated by the creation and maintenance of a separate division called the Division of Mental Health.

The purpose of the Statement advocated by the Royal Commission would be served if in fact the present functions of the Mental Health Division were dispersed into the appropriate areas of the Health Department structure. For example, following a Public Expenditure and Revenue Study Committee recommendation, the hospitals in the Mental Health Division would be transferred to the control of the Hospitals Division. Presumably, Guidance Clinic functions would become part of the Public Health program and their sphere of operations expanded to include consultation and direction of Public Health Unit mental hygiene programs.

Within this suggested framework it should be possible to develop integrated plans for hospital-based psychiatric care. It should also allow medical and psychiatric personnel working in mental hospitals to function in a fashion similar to their colleagues caring for the mentally ill in general hospital psychiatric settings. Placing the mental hospitals under the Hospitals Insurance and Diagnostic Services Act would enable patients in mental hospitals to receive care in the same administrative and financial fashion as patients in other hospitals.

The CMHA contends that a Provincial Mental Health Commission, advisory to the Department of Health, would provide a suitable planning component particularly if designed to involve the significant professional disciplines of psychiatry, medicine, social work, psychology, occupational therapy, and nursing (both registered and psychiatric). The frame of reference should be carefully devised so that it could, and would, function autonomously and independently while retaining definite influence on program and service development.

Regionalization

"Community mental health services should be planned regionally with reference to natural demographic and geographic areas within the provinces, so as to provide facilities accessible to the population of the region."
(More for the Mind)

To facilitate this proposal, we suggest consideration of one of the following approaches designed to promote participation on a regional basis:

- a. There could be established a representative citizens' board concerned with regional mental health services. This board should seek advice, as necessary, from professional personnel involved in providing services to people in the region.
- b. A regional health authority concerned with the operation of health services generally (included would be a mental health committee).
- c. A regional subdivision of the provincial mental health commission. (See recommendation No. 3 under the "Administration and Organization" heading.)

Some financial responsibility should fall to areas desirous of establishing mental health services. Criteria similar to those pertaining to the financing of general hospitals and related services might develop.

Decentralization

To quote from More for the Mind, "When administrative decisions are made locally on the basis of local needs, concern and responsibility are fostered in the community and local involvement is encouraged. There is considerable variation in the needs for psychiatric services and professional personnel. Administrative decentralization permits the necessary flexibility and adaptability in planning appropriate services."

Boards or Regional Mental Health Committees should be established to be responsible for program and policy development. They would also be responsible for apportioning funds received in support of the programs they wish to maintain.

Psychiatrists, as a specialist group within medicine, do not normally have extensive experience in working with community boards or committees (at least not in this Province), so this area must be approached with a spirit of open-minded cooperation. The specialist must be prepared to carefully and explicitly inform those of the public, to whom he is responsible, of the nature and desirability of the programs needed. Alternatively, in a system as suggested, a mental health professional, more accustomed to participation with community boards and committees, might coordinate a program in which psychiatric specialists would be employed, or contracted, on a fee-for-service or sessional basis.

Continuity of Care

This becomes less of a concern if locally oriented services are developed. A patient receiving care in, or close to, his home region or community loses little contact with those important factors which affect smooth return to the community - friends, family, job contacts, etc. Almost every contemporary discussion of mental care warns of the dangers inherent in isolating the mentally ill person.

It has become apparent that hospitalization can be avoided quite often by the provision of suitably staffed out-patient services. Certainly examples exist where mental hospitalization has been avoided by treating the ailing person in a general hospital psychiatric service. Relapses have been reduced greatly by the provision of various types of follow-up programs.

A well-organized mental health program requires methods of financing its services in the same fashion as other health care is financed.

In essence what is required is a "delivery system" of mental health services which allows the mentally ill individual to be treated in his home community or within a 75-mile radius. It should be a system which is designed to prevent hospitalization if possible. Where hospitalization is necessary, it should be as close as possible to the individual's

community, family, and social contacts. After in-hospital care a system of adequately organized after-care services should be available.

Consultation and community education should be planned parts of any community or regional mental health service.

More for the Mind - Recommendations

That local coordinating Mental Health Councils be set up in regions or communities.

That the coordination of psychiatric services be developed on a regional basis following natural demographic and geographic areas within the limits of provincial administration and take into account the adaptation of particular services to local needs.

That all mental health service programs and changes in programs carry with them built-in projects for their evaluations.

Community Services and Facilities

"Mental illness should be dealt with in the same organizational, administrative, and professional framework as physical illness." (More for the Mind)

"A patient is a part of a community and should never lose that identification ... Hospitalization is an episode in treatment and not the entire treatment process ... Hospitalization itself is related to social as well as medical factors. The presence or absence of family or community resources determines the need for hospitalization more frequently than does the actual degree of illness." (Better Social Services for Mentally Ill Patients, Ruth Knee, 1955)

"This need for integrated service in a community has many interesting aspects. It means that instead of thinking of the several agencies which in aggregate make up the community, it is sounder to think of the community as one comprehensive agency for its people." (Integrating Mental Health Services into the Community Health and Welfare Program, Warren C. Lamson, 1955)

Recommendations

1. Implementation of methods of providing adequate mental health services to every region of Alberta should be the paramount objective.
 - a. Priority be given to the development of comprehensive mental health services to the southern (Medicine Hat and Lethbridge) and Peace River areas. Services to include: in-patient

care (preferably locally controlled and incorporated with general hospital services); out-patient care; emergency services; consultation and planning; education (mental health); such development should never take place without very extensive planning and collaboration with local medical and social services.

b. Special attention must be given to providing mental health services to rural areas of the Province.

2. Increased communication between existing mental hospital treatment personnel and community resources, general practitioners, clergymen, social workers, etc., must be developed to assist returning patients. Discharge notes must be mandatory to referring, or certifying physicians, and these physicians must accept responsibility for the returning patients.

Again, we reiterate, "Mental illness should be dealt with in the same organizational, administrative, and professional framework as physical illness." We might add, or paraphrase, by saying, the mentally ill should not be denied access to those effective organizational, administrative, and professional approaches which are successful in promoting recovery in physical illness. (More for the Mind)

However, the five ingredients of Integration, Regionalization, Decentralization, Continuity of Care, and Coordination remain key features in the planning and development of mental health services in communities whether they are urban or rural. This section of the brief will concentrate on adult facilities since children's services are dealt with elsewhere.

Integration

Integration of approaches to the problem of mental illness is crucial to the removal of the present barriers to dealing effectively with this difficult problem. Separate mental health centers, or, for that matter, any specially designated mental health facility should become passé. Integration of mental health professionals into existing public health, educational and treatment services should become part of the approach designed to eliminate differential attitudes about mental illness.

Public health personnel should be as conscious of their responsibilities in promoting mental hygiene as they are in other endeavors they undertake. They should be assisted in this area by mental health professionals either in a direct working relationship, or at least, on a consultative basis.

Regionalization

Basically this term means that an individual requiring care, either in-patient or out-patient, should be able to receive it without any more disruption of his life than for an equivalent physical ailment.

Psychiatric services and specialists in hospitals or in the community should be at least as available and extensive as other medical specialities.

In Alberta there are two very obvious areas lacking in anything near this concept. These are the areas in the extreme north and south of the more populated area of Alberta. Residents of the Peace River country and the Lethbridge and Medicine Hat areas face distances of 150 to 300 miles to get treatment in hospitals where there are organized psychiatric services.

Suggested approaches to problems facing the two areas follow. Integrated into their regional programs would be attention to child, adolescent, and geriatric concerns as they affect the regions.

1. Services for the Peace River area are imperative. A regional mental health service (probably in Grande Prairie) incorporating:
 - a. in-patient treatment including educational facilities for the children being treated
 - b. out-patient treatment
 - c. emergency service
 - d. consultation service to community agencies
 - e. diagnostic and evaluation services
 - f. follow-up process following treatment
 - g. a formal community education program

Such a service should be administered by a locally influential and interested Board of Directors. What is proposed here is a regional mental health service patterned on successful regionalized approaches in other locales. Serious consideration should be given to the establishment of a closed circuit TV system to provide consultation from Edmonton. This would allow people in this region to consult with Edmonton-based services and utilize the advice of the highly specialized professionals even though there may not be opportunity to attract these people to the area.

2. Planning for services in the Lethbridge-Medicine Hat area must involve planning of the development of mental health services. Lethbridge is probably the most appropriate site for a comprehensive mental health service with a satellite development in Medicine Hat General Hospital. Here again a closed-circuit television system between Calgary, Lethbridge and Medicine Hat would be of considerable advantage in utilizing a broad spectrum

of specialized personnel for the treatment and educational benefit of the smaller communities.

3. Alberta must very carefully study patterns of providing care. With relatively minor rearrangements in "delivery systems" of service, the areas within 75 miles of Edmonton, Red Deer and Calgary could be receiving highly improved services which would incorporate most of the desirable features of community mental health services.

For instance, a redeployment of staff at the Alberta Hospital, Ponoka (particularly the psychiatric specialists) could develop a consultative psychiatric service for the central Alberta area from Wetaskiwin to Bowden or Olds. Under existing circumstances this would not be possible. Additional staff, both medical and ancillary, would be required, as well as increased emphasis in reducing the hospital's population by intensifying discharge and after-care programs.

The hospital could also redivide its areas so that a more defined specialization could occur in each area. For instance, a maximum security section could be developed in which the program would be specifically designed to treat prisoners and provide diagnosis and evaluation for remand cases. An active re-motivation program leading to rehabilitation could be developed for long-term patients. This should undoubtedly include the extension of the camping programs presently operated by the Alberta Hospitals.

The suggested approach would mean that each service would have a psychiatric or medical director, preferably a person with special additional education in the particular specialty area concerned.

The Alberta Hospital, Edmonton, would be in an even better position for such rearrangement of service since the proximity of consultation and involvement from university and local medical resources are more readily available.

With such a proposal it is imperative that a great deal of administrative and program autonomy be given the director of the facility in the region. A regional mental health authority would preferably be the planning and policy development body under such a scheme. Alternatively, there should be a mental health segment of a regionally representative health authority or board.

Any buildings in a mental hospital complex, which become obsolete or decrepit, should be razed and careful assessment made about the necessity for replacement in keeping with service needs of the consumer population.

A very detailed reasoning must be developed to support the present pattern of continuing to expand large mental health facilities separate from community influence. This approach is being very critically questioned by a widely representative group of mental health specialists.

Decentralization

Management and administration of psychiatric services should be decentralized. Community representation of the "consumer's" interest has been missing too long in the whole field of mental health services. CMHA recommends an examination of plans in operation, where Government and community have combined to provide regional services, i.e. Nova Scotia, etc.

CMHA would further suggest that no Government-sponsored mental health service, being newly introduced to a region, be undertaken without consultation and planning meetings with such groups as local medical associations, representatives of the municipal council, hospital board, Chamber of Commerce and any other pertinent citizens' group.

Continuity of Care

If there is one glaring fault in existing patterns of care it is the lack of attention paid to continuity in treatment. In spite of an impressive indication of the effectiveness of follow-up procedures, Government mental health services, particularly those which are hospital based, have moved very slowly in developing, qualitatively and quantitatively, adequate follow-up programs. By and large, general hospital psychiatric services have incorporated adequate follow-up programs. General hospital psychiatric services have included some organized commitment to follow-up by social service or home nursing, in addition to the continued post-hospital attention of the treating physician.

Hospitalization is only one phase in the treatment of a mental health problem. Pre-hospital services for emotionally maladjusted adults are extremely limited. Family service bureaus and other community counselling agencies serve a portion of the population needing assistance. Their general relationship, however, to organized psychiatric services is often a chance or arbitrary development rather than one in which a continuum is maintained. There would appear to be definite advantages to organization of adult mental hygiene clinics. The present Guidance Clinic system could be expanded to incorporate services of this nature. Basic service should exist to the point of ensuring any client or patient a diagnostic interview conducted by a professionally qualified member of the psychiatric team; that is, either the psychiatrist, social worker or psychologist should conduct the initial interview. Preferably the service would include the services of all the team members.

An adequate communication system does not exist between mental hospital services and community agencies, medical practitioners or, for that matter, relatives. The Association does not feel the hospitals are any more responsible for this situation than are the people in the community. Distance is a factor particularly in the case of the Alberta Hospitals at Ponoka and Edmonton. There is merit in considering that, within a radius of thirty miles of existing mental hospitals, a physician either referring a patient for voluntary admission, or certifying the patient for care, becomes the treating physician rather than one of the hospital's staff physicians. Beyond this the principle applies that one of the physicians, whose signature appears on a certification document (Alberta Mental Health Act 1964), becomes the patient's physician when the patient returns to the community. Coupled with this would be a requirement on the part of the treatment facility to regularly (not less than monthly) provide progress notes to the referring physician on the patient's treatment (including medication and activity programs and treatment approach). This could be done fairly easily by providing photocopies of regular hospital progress notes and treatment reports. The necessary steps to allow consideration of this approach should be taken.

There is no question that an accelerated program of rehabilitation measures is required. Not only are more follow-up staff required, but development of half-way houses, foster homes and sheltered workshops must be increased. Experiences with these programs indicate their effectiveness. They should be locally operated and controlled (and at least partially financed) but incentive financing should be developed by Government. Whether this becomes a Welfare Department or Health Department concern must be worked out, since both Departments are involved in all of the above-mentioned activities but with differing policies and commitments.

Coordination

General provision of psychiatric services has suffered considerably because of lack of coordination. Communities have a number of in-patient facilities for psychiatric care but still have no adequate program for special concerns, e.g., treatment of the emotionally disturbed adolescent needing hospital care. Plans have been developed for a Mental Health Centre in Calgary without adequate consultation or involvement of local professionals and agencies. It is quite conceivable in this connection that there will be a facility providing duplicate services for groups already served in the community by existing agencies. CMHA is becoming increasingly aware that in the large urban centers of Calgary and Edmonton fairly comprehensive, but poorly coordinated, services exist to serve a large portion of those people with emotional disturbances. Concentrations of mental health professionals have begun to influence the development of services and in time will likely produce, even though uncoordinated, reasonable service to the populations of those communities. Rural areas and smaller urban centers are in need of coordinated approaches

to their particular mental health service needs. They need the assistance of consultants.. This could be provided by the independent Mental Health Commission, to whom application could be made by small urban and rural communities for planning assistance. One of the first requirements, of course, is the development of coordinated regional patterns of service.

More for the Mind - Recommendations

That a rehabilitation service be established as an integral part of the treatment and after-care program and that this service maintain close liaison with appropriate community services.

That local coordinating mental health councils be set up in regions or communities.

That the coordination of psychiatric services be developed on a regional basis following natural demographic and geographic areas within the limits of provincial administration and take into account the adaptation of particular services to local needs.

That for many centers of population, adequate hospital services be met by providing psychiatric units and services in existing general hospitals.

That psychiatric units in general hospitals have an organized out-patient department, in-patient treatment and consultative service, and a 24-hour emergency service for the community.

That non-hospital facilities in the form of domiciliary care, foster homes, homes for the aged, be developed separately from the hospital facilities for those patients who do not need further clinical psychiatric treatment.

That adequate geriatric services in a community include acute hospital beds, long-term hospital beds, long-term residential care and foster home settings and day centers.

That there be provision of psychiatric consultation to all geriatric services in a community.

That there be ease of movement between all geriatric facilities of a community.

That at the community level, child and adult care be provided in such a way that community clinics and out-patient departments provide family care.

That psychiatric services to non-medical community agencies be on a consultative basis.

That local planning for the distribution of psychiatric facilities take place in conjunction with the planning of general hospitals.

That the community provide assistance where necessary to enable patients with residual disability to live in the community, such assistance to include the provision of appropriate psychiatric consultation services.

That except where services are an inseparable part of another provincial facility, the provincial government withdraw from the operation of diagnostic and treatment services.

Manpower

Utilization and Development

"People are the principal therapeutic agents in psychiatric services; neither drugs, nor physical treatment, neither diets nor decor, but people." (More for the Mind)

Recommendations

1. Establishment of an interdisciplinary "task force" group to devote itself to the task of maintaining sufficient personnel in mental health services so that quality of care to the mentally ill is improved and such improvement in care is maintained.
2. High priority must be given to improving Alberta's ability to provide mental health professionals from its own educational institutions, particularly psychiatrists, social workers and clinical psychologists.
3. Attention should be devoted to improving career possibilities in the Mental Health Division services particularly as they apply to psychiatrists, social workers and clinical psychologists.
4. There should be immediate attention devoted to extensively broadening research and education activities for staff within the services operated by the Mental Health Division, Department of Health.
5. That the community physician be the link between the patient's pre- and post-hospital medical treatment and every effort be made to prepare him for such responsibility by providing him with proper education and information. Reliance should be placed as well on other "gate-keeping" professionals - teachers, public

health nurses, etc., and they should be assisted to cope with mental health problems they encounter among their clientele.

6. Involvement of volunteers in all phases of mental health programs must be developed and maintained, on regional boards, in education programs, service programs to patients, etc.

Manpower

"People are the principal therapeutic agents in psychiatric services; neither drugs, nor physical treatment, neither diets or decor, but people." (More for the Mind)

This statement might be shortened to the "Brains before Bricks" theme so often prescribed by Dr. Wm. Menninger when he spoke to legislators and influential groups on behalf of the mentally ill. Shortages of staff in Alberta's mental health services are creating situations where many patients are not receiving appropriate attention to their problems.

The provision of adequate professional and ancillary personnel is an absolute necessity to the maintenance of any program, which will sustain an acceptable level of services. Alberta must increase efforts to educate professional and ancillary personnel so that staffing does not rely mainly on recruitment from other countries or other areas of Canada. (Few of the psychiatric graduates from the University of Alberta are working in services operated by the Alberta Health Department.) Within this approach there must be developed programs of research, education and treatment of sufficient scope and interest to retain staff educated in our Province. This applies particularly to Mental Health Division Services.

Judging by the examination of other areas, the maintenance of progressive, dynamic and flexible mental health services is one of the key factors in attracting staff at the professional level. Treatment services, which have integrated research and education programs, are necessary to retain staff once they have been recruited. Examples of this exist in Alberta where good numbers of staff are available to general-hospital-based psychiatric services in contrast to continuing staffing problems in Alberta's mental hospitals. Appropriate income levels for staff are essential, but these are usually established within the framework of the programs and take into consideration the competitive nature of staff recruitment. There is merit, too, in developing service systems, which allow for fee-for-service, sessional and other types of remuneration for professional services. Operating mental health services in the same framework as other health services would greatly assist.

CMHA suggests that closer interdisciplinary collaboration would improve the provision of services. There appears to be, for instance, little reason to exclude psychiatric nurses in this Province from head nurse and senior nursing responsibilities in general hospital psychiatric

units. The scarcity of registered nurses, with as much preparation in the psychiatric field, seems to suggest the impracticality of maintaining this restrictive practice. CMHA hopes these two nursing bodies and the Alberta Hospital Association will work together to solve this problem. Increasing the number of senior social work and psychological positions of most existing mental health services would improve the possibilities of interdisciplinary contributions to treatment programs.

Lack of after-care staff hampers development of rehabilitation programs now. Additional psychological help in making vocational and other assessments would increase considerably the results being obtained. Additional social services staff are required, as well, to facilitate successful programs.

Competition between various Government departments, municipal and private services quite often leads to inefficient utilization of mental health professionals. More coordination would obviously improve the effectiveness of utilizing existing personnel.

Regionalizing services and decentralizing administration would assist in developing programs which would have the potential for increased recruitment. The ability of regions of the Province to recruit mental health professionals in keeping with regional needs and services would be a distinct advantage over the present approach.

CMHA sees merit in the establishment of an interdisciplinary task force to attend to the problem of staffing the broad spectrum of mental health services. Such a force would give high priority to program evaluation, research opportunities and educational aspects as ingredients of staff development, recruitment and retention. Their concerns would also include working relations between various professional and sub-professional personnel. In this context special attention must be given to providing increased educational and consultant support to the "gate-keeping" professionals, the general practitioners, teachers, public health nurses, clergymen, etc.

There is a need to develop approaches which allow fuller utilization of mental health professionals. The established tendency of such personnel to gravitate to urban centers is not likely to change so the planners of mental health services have to devise methods of using such talent for the benefit of rural areas, both in the areas of treatment and education.

CMHA wishes to emphasize in the strongest possible terms the value of involvement of the lay public in mental health programs. Volunteer service can reduce the costs of many programs and expand the dimensions of many programs by relieving staff to perform more professional duties. They also form the most visible, valuable link between the patient and the community he may feel has deserted him because of his illness. A far

closer relationship between mental health professionals and the lay public is essential if quality of mental health services is to be maintained at the level the professionals consider adequate. In this sense the lay public are volunteers, active in developing opinion in support of professionally established goals.

More for the Mind - Recommendations

That professional staff in psychiatric services be freed as far as possible to perform professional functions by the provision of adequate clerical assistance.

That workers with less training than that required for professionals in psychiatric services be introduced by the various professions to assist in filling various service needs.

That clinical psychiatrists work, wherever possible, in a diversity of settings.

That aides and orderlies be considered administratively and functionally part of the nursing service.

That in psychiatric facilities, administration be the responsibility of a psychiatrically trained medical administrator.

That medical personnel with administrative responsibilities be appropriately trained for this work.

That lay assistants be responsible to the medical administrator and capable of being trained in the medical significance of their task.

That each mental health profession pay more explicit attention to the kinds of careers now available to its members and to the possibility of joining various other activities with clinical services and to relating career opportunities to the training programs in universities.

That each mental health professional group in each province establish a career development plan for those engaged in mental health services.

Services for Emotionally Disturbed Children

"Treatment of mentally ill or emotionally disturbed children requires methods, techniques and skills fundamentally different from those used with adult patients. Children cannot be regarded as midget adults."

(More for the Mind)

Recommendations

1. Immediate creation of provincial and regional councils on provision of effective services for emotionally disturbed children; representation to include citizens (strongly represented), private care agencies, Juvenile and Family Court, school boards, welfare, health, and municipal representatives. This group should have defined authority to implement recommendations and have access to funds for that purpose.
2. Each agency, of sufficient size, which is directly involved in the problem of emotionally disturbed children and adolescents, appoint one professional person to devote at least half-time to liaison and educational activities with other community agencies and the general public.
3. The Government departments involved with troubled children and adolescents actively pursue collaboration which would result in a coordinated "delivery system" of services to children needing help.
4. That residential and day-care facilities be developed more extensively, particularly in those areas having no such services at the present time.

Services

Services needed for treatment of emotionally disturbed children roughly parallel those required for treatment of adults. Thus, in-patient services are needed for short-term diagnosis and for continuing care. Continuity of care should be ensured between in-patient services and the community, and between services within the community. Day hospitals, out-patient departments (or services) and community clinics are all required for child services. Recent reports indicate severely disturbed children can be treated on an out-patient or day-care basis.

General Considerations

Integration

In the Province of Alberta there is very little indication that services for severely emotionally disturbed children are being integrated into other services for children. Only one general hospital (University) in the Province has a Pediatric Psychiatric Service. There are two other hospital settings (Glenrose and Alberta School Hospital) in which emotionally disturbed children are treated. In the area of the Province south of Red Deer, there are no hospital-based services for emotionally disturbed children.

There are emotionally disturbed children being cared for in non-hospital services and in a number of out-patient settings. A significant number of emotionally disturbed children are served by special services in school settings indicating a semblance of integration in this setting. A distressing frequency of reports suggests that emotionally disturbed children are often held in detention centers because there are no other facilities or services.

Regionalization

There is, perhaps, more reason to create regional services to treat emotionally disturbed children than there is for adults. Contemporary opinion strongly supports the necessity for involvement of the family in the treatment process, which would naturally suggest a reasonable proximity of the treatment service to the child's home community.

"Reasonable proximity" is generally considered a distance involving a trip by car of no more than one hour and a half, suggesting a service in the middle of an area with about a 75-mile radius.

Any regional service for children should provide within its framework:

1. In-patient treatment including educational facilities for the children being treated.
2. Out-patient treatment.
3. Emergency service.
4. Consultation service to community agencies.
5. Diagnostic and evaluative services.
6. Follow-up process following treatment.
7. A formal community education program.

To repeat, there are medically directed in-patient services for children in only three settings in the Province, and none in the area south of Red Deer. Two other facilities in Calgary maintain 24-hour care for emotionally disturbed children and there are similar settings in Edmonton. It is safe to contend that the provision of in-patient care is extremely sparse and not equitably distributed.

Out-patient attention for emotionally disturbed children is available in more communities and regions through a variety of approaches. In the large urban centers of Calgary and Edmonton the list of involved agencies would include: Guidance Clinics (Department of Health); special education and guidance services (school boards and Department of Education); private agencies; city health departments.

Smaller communities devise whatever approaches they can muster within the framework of their resources and the amount of community concern. Rural areas are virtually devoid of effective services.

Generally, the development of services for children with emotional problems has not been organized to provide the necessary services on a regional basis.

Decentralization

This relates to the management and administration of psychiatric services which should be decentralized. In this context there are interesting comparisons. Local school boards develop approaches to emotionally disturbed children within the school system, while Guidance Clinics of the Province are centrally directed and administered, offering a fairly tightly defined service wherever they occur in the Province. Often both the above-mentioned agencies are dealing with the same child. More flexible, regionally-oriented management and administration for Guidance Clinics might make it possible to avoid existing duplication of service, and allow a shift into complementary areas of service.

The possibility of a Regional Commission on Children's Mental Health Services bringing more cohesion and effectiveness is worth consideration. This group would, of course, relate to any provincially-established Commission of a similar nature.

Continuity of Care

Present distribution of children's in-patient treatment services and the variety of organizational and institutional patterns in areas of the Province makes continuity of care almost impossible. The blurred areas of responsibility between the Departments of Health and Welfare, private agencies and school boards, make the unhindered movement of a troubled child from one area of attention to another fraught with complications which are often anything but helpful.

Too many gaps in community services and the organization of these services lead to the benefits of existing treatment being dissipated quickly because overall operations do not provide continuity of care.

Coordination

If there is a major deficiency existing in the development of services for emotionally disturbed children it appears to relate to lack of coordination.

A minimum of four Provincial Government Departments have indicated the existence of some form of mental health or social readjustment service to children and adolescents in their programs. The Department of Health, Department of Welfare, Department of Education and Attorney-General's

Department all are employing, or are attempting to employ, mental health professionals to assist in programs for troubled children and youth. The Department of Education is, perhaps, most indirectly involved since local school boards are responsible for the programs developed in their own areas.

Personnel, the core of any program, are, therefore, competitively sought by different systems whose ostensible purpose is to assist the troubled child. Programs are developed by various agencies in relative isolation from the rest of the community activities devoted to the same purpose. It is CMHA's opinion that improved coordination and cooperation between existing services and agencies would greatly benefit the "consumer" of the service.

More for the Mind - Recommendations

That schools provide special classroom facilities for children with emotional disorders.

That school systems do not develop psychiatric diagnostic and treatment services of their own.

That on identification of an emotional disorder in a school child, the family be responsible for, and involved in, seeking psychiatric help from the beginning.

CHAPTER 12

FARM WOMEN'S UNION OF ALBERTA

Members of the Union, representing 20,000 rural farm units, welcome the opportunity to submit the following views on Mental Health. In this brief we endeavor to deal with the most crucial problems in the mental health field as we perceive them, designating the areas where shortcomings exist, and point out where we feel that immediate action is required to improve mental health services for the people of our Province.

While we contend that mental health is everybody's business, we find that the magnitude of the problem has not been grasped by the average citizen. We believe, therefore, that it is of the utmost importance to establish a comprehensive mental health program which will provide information concerning mental illness, aimed at greater public understanding of this problem, and responsibility toward it.

Enlightened opinion today regards people who are mentally disturbed as sick, and deserving of consideration and individual care equal to that granted to people who are physically ill. However, mental illness is still surrounded by an aura of horror, fear and superstition. It differs from physical illness in that it tends to disturb and repel others rather than to evoke their sympathy.

While physical illness can be diagnosed and the extent of injury or disease determined, mental illness cannot be so easily measured, but requires specialized psychiatric therapy.

Another difference, and one that needs to be corrected without delay, is that we have been guilty of negligence by ostracizing our mental patients in isolated and often over-crowded institutions which we feel is not conducive to effective recovery.

Education as a Preventive Measure

The prevention of psychiatric disorders cannot be left to the psychiatric or medical profession, neither is it the sole responsibility of family physicians, neurologists, social workers or governments. To take all necessary preventive measures we need the collaboration of public health units, schools, industries, economists, sociologists, teachers and clergy.

Above all we need to motivate parents, in the homes, and parents-to-be to raise children who will be healthy emotionally as well as physically. There is a definite need for family life education programs with emphasis on human values and responsibilities. Discussion seminars at the community level would provide an excellent opportunity for lay people to

come to grips with the wide aspects of mental health. Recorded case histories and films could form the basis for discussions. Voluntary organizations can do great work in the field of public education and social services, if given the opportunity and encouragement.

In our educational institutions more emphasis needs to be focused on guidance and counselling by qualified personnel with psychological training. We believe that much more could and should be done to reduce psychiatric disorders through counselling as a primary preventive measure, to counteract harmful circumstances before they have a chance to cause illness.

As early childhood appears to be the crucial time when behavior patterns are set, specific orientation in psychology and guidance should be among the basic qualifications for teachers of kindergartens and day-care centers. Children at school have emotional problems which teachers lack the training to recognize and cope with. Guidance counsellors with psychological training can do much to alleviate mental stress and to curb emotional disturbances.

Psychiatric clinics need to be established in regions where they will be accessible to all who do not respond to counselling; where those with deep emotional disturbances may receive specialized therapy on a long term basis if necessary.

Care and Treatment

Mental illness should be dealt with in the same organizational, administrative and professional framework as physical illness. Frequently our attention is drawn to the unsuitable treatment that patients have experienced while confined in our mental institutions. They find themselves excluded from society, cut off from all that is familiar and dear, to spend months and even years behind an endless succession of locked doors, as though they were criminals. To find themselves confined in wards that are overcrowded, far in excess of a normal limit, together with patients extremely disturbed, is both frightening and alarming.

People, who are physically ill and confined in hospitals, do not tolerate such congestion; they demand privacy and individual care. Although mental patients deserve the same service and care, it is often not available; in stark contrast, they are robbed of all human dignity because they are unable or unwilling to speak for themselves. When they do venture to protest, their opinions and requests are often not taken seriously.

We therefore recommend that psychiatric wards and psychiatric treatment services be integrated in our general hospitals on a regional basis in order that mental patients may receive immediate help and individual care, through all phases of illness, without interruption; and that the future development of all mental hospital facilities be in close proximity to medical centers.

Staff

The serious shortage of staff in our mental institutions is indicative of the difficulty that is encountered in attracting people into this health field. This, we believe, indicates that there exists an urgent need for salary revisions in all the levels of our mental hospital operations. It is evident that the salaries paid to psychiatrists and nursing staff in our mental institutions are inadequate and consequently do not attract the qualified personnel needed on a permanent basis. The result is short term service for training and experience only.

Among the grievances reported are the attitudes toward, and treatment received, from staff members, which is inconsistent with the care and concern for the well-being and human dignity that one associates with hospitals.

With the current development in chemotherapy and other treatment methods, it is becoming increasingly evident that more mental patients can be treated in other than large institutions, e.g. at home, in general hospitals, in out-patient departments and nursing homes.

Rehabilitation

Therapeutic treatment and psychiatric care should not cease when a patient is discharged from a mental hospital. Preparation for discharge, after-care, and rehabilitation are all integral parts of the psychiatric treatment process. Here again public education is of vital importance. Over and over again we are told of cases where relatives and well-meaning friends, because they had not been adequately informed, have been instrumental in undoing what has taken years to correct.

We present the following recommendations:

1. That mental illness be dealt with in the same organizational, administrative and professional framework as physical illness.
2. That the psychiatric treatment services be integrated with the physical and personnel resources of the rest of medicine.
3. That psychiatric treatment services be established in centers of population on a regional basis.
4. That an intensive educational program in mental health be made available to the public by the Department of Health in collaboration with the psychiatric profession, with special attention to after-release care and job opportunities.

5. That family life education programs and seminars be generated with emphasis on the basic human values. (Voluntary organizations could play an important role in these educational spheres, if given the opportunity and encouragement.)
6. That there be less overcrowding in wards and more privacy in our existing mental institutions.
7. That psychiatric wards be integrated into all general hospitals, with special attention to the isolated areas of northern Alberta.
8. That salaries for psychiatric personnel be revised to attract competent personnel on a more permanent basis.
9. That psychiatric units in general hospitals have an organized outpatient department as well as inpatient treatment and consultative service.
10. That Provincial Guidance Clinics be expanded to provide more services for more people, specifically in pre-admission and post-discharge procedures.
11. That rehabilitation programs be given high priority as a continuum and be an integral part of the treatment process.
12. That special training be provided for teachers to work with groups of disturbed children. That kindergarten and day-care personnel be required to have psychological training.
13. That centers under psychiatric direction be set up for the care of the retarded.
14. That the care of mental patients be incorporated under the present or any pending health plan.
15. That the public be encouraged to offer bursaries to increase the training of social workers.
16. That during the period involved in transportation or examination, mental patients not be confined in jail cells.
17. That recruitment, training and career programs for professional personnel in the mental health field be increased and improved.
18. That psychiatric services provided for addicts in jails or penitentiaries continue as far as possible after drug withdrawal and release.

19. That prisoners with mental illness receive definitive and specific psychiatric treatment.
20. That the management and administration of psychiatric services and mental institutions be decentralized.
21. That guidance counselling be made available in all educational institutions and that this service be extended to include preschool children.
22. That psychiatric services in hospitals, clinics and other centers be coordinated to provide maximum effectiveness.

SUMMARIES OF REMAINING BRIEFS

1. ALBERTA EPILEPSY ASSOCIATION

It is necessary to re-assess the physical and mental conditions of persons with epilepsy, on welfare or in institutions, to update their treatment. Possibly a change in medication could help them become more independent.

A public education program should be launched to overcome public fears, superstitions and misunderstandings concerning epilepsy. The word "epileptics" should be removed from the sterilization law and mental diseases act in the Province.

2. ALBERTA GUIDANCE CLINIC, CALGARY

Twelve topics were examined and recommendations were submitted on each, as recorded in this section.

Current organization and administration of services were considered too centralized and restrictive; there was a lack of well-defined policies; one-way communication was common; and there was little encouragement of local research, teaching, in-service education or other staff development. Results were reported to be inadequate services and low morale as reflected by abnormal staff turnover. Recommendations included: decentralization of administration to local levels, formation of regional "boards of control" responsible to the Minister, encouragement of local involvement in the provision of services to the fullest extent, divorcement of the Government from the direct operation of services from Edmonton, qualification of all administrators in business and hospital administration.

Manpower was considered insufficient to meet the need for services; positions were filled in Government facilities too often by poorly trained workers; working conditions would not attract the right people (e.g. lack of active two-way communication and other indicators of good leadership, lack of opportunity to teach and do research, inadequate remuneration and fringe benefits like continuing education). Results can be inferred and recommendations related to the provision of more qualified people and the correction of the above deficiencies in personnel management and development.

Research, particularly operational research at Government facilities, was seen as a means of solving some current problems and of maintaining professional interest and competence. Currently neglected, this activity should become an essential part of operations and service should not be stressed to its exclusion.

It was contended that emotionally disturbed children and adolescents need special service, including treatment by "children's psychiatrists" (only two were reported to be in practice in Alberta in 1968). Alberta Guidance Clinics, complemented by residential facilities, were seen as a major resource in this field, if properly staffed in numbers and quality.

The development of a psycho-educational service in Calgary was urged to meet the needs for expert diagnosis and programs of treatment and training in the case of intellectually and neurologically handicapped children. One of the major problems was regarded as the coordination of the efforts of medical doctors, educational psychologists, special educational services, social workers and nurses working under different auspices.

Greater involvement of psychiatrists, in company with psychologists, now providing service, in student counselling services at universities and colleges was seen as a desirable development. The "team" approach, generally advocated and sometimes followed in other settings, involving psychologists, social workers and psychiatrists, was considered applicable in the setting under discussion, too. The same conclusion was advanced regarding counselling services in schools. They were judged to be an important element in the prevention of more serious mental illness.

Another topic, "community facilities for mental health" was closely related to the consideration of organizational and administrative deficiencies and improvements. It was suggested that coordination of the many community facilities could be realized only through the creation of regional "boards of control" which would assume operational control over all facilities of the Provincial Government, which now provide diagnostic and treatment services and care, and all other similar facilities in a region.

Another call for coordination of assessment, diagnosis, treatment and after-care was made in the case of drug and alcohol abuse. It was reported that there was no coordination at the time the brief was prepared in 1968.

A psychiatric institute, rather than a community mental health center, was proposed for Calgary comprising the following elements: geriatric; forensic; active treatment for adults only (special children's services would be provided at the Children's Hospital) both in-patient and out-patient; the Alberta Guidance Clinic with residential facilities; a composite of facilities for the mentally retarded, including schools and the V.R.R.I.; research (operational, clinical, basic); education (for mental health professionals); and a special element for handicapped persons (not including the retarded, who were referred to earlier). Under the plan, mental hospitals would be regionally located, limited to 300 beds; general hospitals would have 10% of their beds designated as "psychiatric" and family physicians would be able to admit and treat with psychiatric consultation; auxiliary hospitals would be used for certain "mental"

patients requiring continuing care; residential arrangements for mentally retarded who can not be handled within their communities should be provided on a regional basis with workshops, vocational training and close liaison with community agencies. Any further building would take place only after full consultation with local authorities.

It was argued that the psychiatrist should be chairman of the mental health team because he, alone, can take responsibility for the total health of a patient, mental and physical.

The brief also proposed that a "start" should be made to establish forensic services in Alberta. The form recommended was a division of a Psychiatric Institute in Calgary.

3. ALBERTA GUIDANCE CLINIC, EDMONTON Psychiatric Social Work Department

Federal Health Grants

Federal Health Training Grants should be continued. Monthly stipends should be increased to the maximum allowable under the Federal regulations, which is \$250 for a single person without dependents and \$300 for a person with dependents. Alberta pays the lowest monthly stipend of the provinces. The book allowance should be raised to \$50, in accordance with the Federal regulations, instead of \$25-\$35. The return-in-service commitment should be reduced to the minimum amount allowable by the Federal regulations which is based on a year's service for a year's education. Federal Health Grants should be offered on a competitive basis without requiring a year's employment for eligibility. The number of these grants should be increased and their availability should be advertised in the University's Awards Calendars.

Salaries

Too many persons with divergent educational qualifications and levels of authority are squashed into too few positions, e.g., a Psychiatric Social Worker II position includes both a person who has only attended a school of social work for one year, as well as a person who has completed two years required for the Master of Social Work degree. A re-classification of positions is required.

There should be a salary differential between the B.S.W. and the M.S.W. of at least three increments to ensure adequate recognition for the M.S.W.

Salaries should be revised in order to obtain and retain professionally qualified social workers with much greater emphasis being placed on the need for "core staff," i.e. supervisory and administrative personnel.

4. ALBERTA HOSPITAL, CLARESHOLM

We should strive towards attaining accreditation for our active treatment mental hospitals.

Where possible the Division of Mental Health should try to integrate the scope of its services with the Provincial Hospitals Division.

Qualified hospital administrators should be used on the administration of the day-to-day affairs of our institutions.

The public requires education to encourage support of mental health.

5. DR. D. S. BISHOP

Mount Royal Junior College, Calgary

The medical profession should take a stand on mental health. It should invite participation by other disciplines and thereby take the lead in multi-disciplinary approaches. We should admit our limitations in mental health and consult on a meaningful basis with other disciplines, such as educators, jurists, counsellors, clergy, psychologists, etc. We should tabulate the problems causing the greatest morbidity, and attack these problems with a multi-disciplinary approach aimed at care and prevention. We should agree that more exposure to research techniques would aid all physicians.

6. MR. JOHN BULL

The mentally ill should be given a chance to live in our society as useful human beings.

Hospital facilities should be increased; some doctors should be encouraged to enter the field of psychiatry and others should become more knowledgeable in this field; the public, and particularly churches, should be made more informed about mental illness; and employers should attempt to assist former mentally ill patients to obtain employment.

7. CALGARY FAMILY SERVICE BUREAU

Within the planned mental health complex in Calgary, the following should be incorporated:

An out-patient department including adequate numbers of highly trained personnel from professional disciplines, such as social work, psychology, psychiatry, occupational therapy, nursing and physical medicine, to provide a high quality assessment and treatment service for the public. Emergency services should be available.

A day-treatment center should be developed, within or separate from the out-patient department, to provide for patients, who require partial hospitalization, either during the day or night before they can tolerate complete separation from the hospital.

A research department should be developed to include representatives from the helping professions and other social and behavioral sciences, to conduct on-going research into the reliability and validity of treatment and rehabilitative methods.

A community resettlement department or program should be established to locate and maintain high standard foster homes and half-way homes; to maintain adequate follow-up services with discharged patients and their families; and thus promote integration of the patient, family and community.

Homemaker services should be more fully utilized for families where inadequacy or disorganization on the part of one or both parents inhibits or prevents the emotional rehabilitation of a disturbed child.

A social and recreational program should be developed in the complex, using the various helping professions for consultation and drawing on a pool of community volunteers to provide the additional human contact that patients require.

The entire mental health program should be geared to the goal of prevention, early detection, effective treatment and lasting rehabilitation.

8. CANADIAN ASSOCIATION FOR CHILDREN WITH LEARNING DISABILITIES, CALGARY

The Department of Education and university faculties should initiate specific training for teachers on recognition of children with perceptual and other multiple handicaps so they may be referred for treatment and programming through guidance channels or special education departments.

Teachers should be given the opportunity to receive instruction or training regarding perceptual and multiple handicapped children and youth through in-service programs or summer courses.

The Departments of Education, Health and Welfare should make a coordinated effort to establish diagnostic services utilizing existing services, e.g. at Calgary Foothills Hospital, Psychology and Education Departments at the University of Calgary, and to coordinate diagnostic services in other areas of the Province.

• Diagnosing and programming could be planned by such a center, with treatment being carried on by existing services, using volunteer agencies, if they are preferred to Government-sponsored departments.

Consideration should be given to funds for research to determine the most advantageous method of establishing coordinated facilities for all multiple handicaps in Alberta.

Memoranda should be sent to schools and superintendents in an attempt to create an awareness and understanding of children with perceptual learning disabilities.

A "team approach" would be most beneficial in the treatment and diagnosis of all multiple handicaps in Alberta. (The Institute of Logopedics, Wichita, Kansas is an example.)

Programs should be established at pre-school and elementary levels, for perceptually handicapped children, and special classes with qualified personnel should be set up.

Kindergarten and primary teachers should be trained to administer required tests to all children entering school, and personnel should be trained to score the tests.

Handicapped children should be provided with necessary aids, e.g., oral exams, audio-visual aids, etc. Children at the secondary level should be provided with modified courses leading to university training.

9. CANADIAN MENTAL HEALTH ASSOCIATION, CALGARY BRANCH

A children's service council should be created with representation from all facilities providing services to children, e.g. private agencies, Juvenile and Family Court, school board guidance department, welfare agencies, Alberta Guidance Clinic, child psychiatrists.

The council should study mental health services for children in Calgary and provide guidelines for the development of integrated services and facilities for the early detection, treatment and prevention of emotional disorders in children.

One agency should assume responsibility for the coordination of the treatment program of the child and his family although a number of agencies may be involved.

The concept of treating the patient as a member of a family unit should be encouraged in the development of services for emotionally disturbed children.

Realistic increases should be made in the number and size of bursaries for students in various mental health professions.

Immediate attention should be given to providing educational facilities for child psychiatric personnel.

All agencies should be encouraged to institute in-service educational programs and financial aid should be made available for these programs.

Psychiatric services for children should include residential facilities for young adults over 16 years of age.

Every city hospital should have adequate bed space so that children and adolescents can be cared for on children's and adolescent's wards unless it is preferable for specific clinical reasons, to place them on adult wards. Children for whom adult ward placement is indicated should receive specialized services.

Community centered mental health programs in all areas, remedial, preventive, educational, and aftercare, should be established.

10. CANADIAN MENTAL HEALTH ASSOCIATION, EDMONTON BRANCH

The Branch endorsed the brief from the Alberta Association in its entirety and focused attention on the work of volunteers "as a significant component in patient recovery." They help in particular in bridging the gap between the community and a hospital necessarily located outside the community.

Their brief urged that non-professionals, like hospital aides and housewives, be trained as lay mental health counsellors to meet the needs for service which can not be met by professionals, even at most optimistic projected rates of production. They noted that studies have proven the effectiveness of non-professionals when trained and supervised properly.

It was observed that the Government "can not be held accountable" alone for the provision of improved services and pointed to the community as largely responsible. Moreover, "we should face the fact that the ramifications of mental health go far beyond the field of medicine" pointing to other professions, like education and social welfare, which are "deeply involved."

The avoidance of alienation and isolation, of people who become mentally ill, was seen as a crucial need by the Edmonton Branch of C.M.H.A. They said "It seems that the approach in the past has been that a patient can go from doctor to doctor, can often encounter different well-meaning social agencies, can be exposed to different people with different orientations and finally end in a mental hospital miles away from his own environment. It seems that the process of alienation is promoted by the services which exist to prevent it." Their solution is regional mental health facilities, where people can get help with their troubles often not having to go farther than an out-patient facility.

A necessary foundation was considered to be administrative decentralization with operational authority assigned to regional bodies or "community management." The role of the Division of Mental Health would be changed from "management of direct services to one of the coordination and integration of services." It would promote community participation and education, stimulate the establishment of regional centers, provide financial subsidies, coordinate and promote research, and promote the provision of professional education and continuous training.

The brief expressed the belief that the City of Edmonton and its citizens are ready to participate; so it was recommended that a regional "mental health authority" be established there, responsible to the City Council and appointed by that body. An inter-disciplinary advisory committee would also be established (general medicine, psychiatry, social work, clergy, law, education, business, nursing, labor, rehabilitation, public health, psychology, sociology and anthropology). The "authority" would be responsible for all public mental health services in the community (e.g. Alberta Hospital, Edmonton; the Alcoholism Division and the Alberta Guidance Clinic) and would have authority to extend services into forensic, homecare, crisis intervention and adult diagnostic and outpatient areas. It would also be responsible for close working relationships with related departments, e.g. Pupil Personnel Services.

The Edmonton Branch recognized attendant difficulties (legal, organizational, financial, and others) and says that courage, above all, will be necessary to make the changes which would lead to a "comprehensive system of prevention, treatment and rehabilitation" in the field of mental health.

11. CATHOLIC WOMEN'S LEAGUE

St. Michael Archangel Parish, Edmonton

The public should be involved, acting on boards responsible for mental hospitals and as a mediator between hospital administration and the Department of Health.

Administrative duties should be assumed by qualified hospital administrators, thereby freeing psychiatrists to devote their full time to the welfare and treatment of patients.

More psychiatric units should be established in general hospitals.

Community mental health clinics should be established. They should provide diagnostic and treatment services for a broad range of mental health problems both before and after hospitalization, both day and night treatment. Capable people must be attracted to initiate and develop these necessary mental health programs; competitive salaries should be in existence. A travelling unit should serve outlying areas.

Decisions affecting mental hospitals should be made by individuals who deal with the patients. Too often these decisions are made by administrators, who have little contact with the patients, the community and the staff.

Geriatric units are required to give more active treatment to the aged mentally ill. Nursing homes need more qualified staff to take care of the elderly.

Separate facilities should be provided for the criminally insane, drug addicts, younger teen-aged and twenty-year-old emotionally disturbed persons.

Mental hospital services should be financed under the Hospital Insurance and Diagnostic Services Act on the same terms as care for the physically ill.

Group and occupational therapy services should be provided.

Suitable places for religious services are required.

Recruiting in imaginative ways should be instituted; competitive salaries should be offered.

Research and public education dealing with mental illness should be carried out.

12. CEREBRAL PALSY ASSOCIATION, CALGARY

The Cerebral Palsy Clinic should extend its facilities to admit a child at a younger age, 1 to 1½ years. The Clinic should educate the cerebral palsied (CP) to his capacity, even if it is on a very simple level. Extended educational facilities are required for those with the ability for higher education.

Extended day care facilities are required. The Day Care Centre treats CP children who cannot be fitted, either mentally, or mentally and physically, into the Clinic's routine, but do require daily therapy and individual attention.

The CP Work Shop facilities should be extended in order to rehabilitate the CP adult to his capacity and to provide an outlet for those who are not trainable but require a routine and an environmental stimulus.

More buses are required to transport the children to and from the Clinic, Day Centre, etc.

Residence Recommendations:

Cottage type dwellings should be established, rather than institutional dwellings. These should house six to eight children, no sex or age segregation, with permanent house parents. Services of aides, assistants, and professionals should be utilized, e.g., V.O.N. These dwellings should be under the supervision of a medical officer or an appropriate body. Assessment for admission to the residence would automatically include those CP now accepted in the present facilities. The severity of the handicap would not be a determinant. Bus transportation would be provided for resident children.

13. CHAPLAINCY ADVISORY COMMITTEE

Calgary General Hospital

A broadly representative group, in existence for six years (in 1968), the Committee recommended:

- a. more rehabilitation programs for "mental health patients," pointing to a small industry for rehabilitating alcoholics started by Trinity United Church;
- b. the encouragement by Government of family counselling clinics, noting as three examples those of the Catholic Family Service, the Jewish Family Service Bureau, and the United Church Pastoral Institute;
- c. more half-way houses (Calgary has one, for men);
- d. local residential schools for emotionally disturbed children;
- e. establishment of ex-patient groups for fellowship;
- f. walk-in psychiatric clinics on a 12-hour basis to help provide help when it is needed;
- g. boarding (as paying guests) of ex-patients in private homes.

14. CIVIL SERVICE ASSOCIATION OF ALBERTA

Psychiatric nurses should be recognized as a proper discipline to deal with the mentally ill. They can also be employed in smaller centers in a social work capacity to promote hospital-community involvement.

Research in all areas of mental illness should be promoted.

Consideration should be given to the pay differences between professional personnel in nursing fields as compared with tradesmen. In many instances salaries are much higher for tradesmen.

All hospital settings should be utilized for personnel training, e.g., occupational therapists could receive training at large centers.

Hospital-community involvement and integration should be developed.

All institutions should be assured of adequate medical, dental and ophthalmic services, preferably resident.

Patients should be kept in hospitals closer to home and relatives. They should be treated in psychiatric wards in municipal hospitals before being sent to mental hospitals, if necessary. Social workers should keep friends and relatives aware of patients' condition and wants. Where possible, patients should be taken home frequently.

Sidewalks and good roads should be provided to all hospitals so patients can walk to stores, etc. More entertainment is required in smaller hospitals.

Vocational training should begin at Grade 9 or sooner for any child to channel his aptitudes and eliminate the mental strain that causes dropouts and mental breakdowns.

More social workers should be available in each county.

15. COMMITTEE OF PARENTS OF AUTISTIC CHILDREN, CALGARY

Immediate steps should be taken to provide adequate facilities, staff, program, buildings, and equipment for the treatment of autistic and severely disturbed children. Fully self-contained apartments for four to six children should be the basic housing unit in the proposed Calgary Mental Health Centre. This complex should make provision for experimental and research programs.

The control of policy and administration of the proposed Calgary Mental Health Centre should be vested in a local board, as is done with general hospitals, rather than with the central Provincial Government and Civil Service.

16. DR. P. M. CROCKFORD

Division of Endocrinology, University of Alberta

Arrangements should be made at all mental institutes that non-psychiatric medical specialists can be called on for consultation. The psychiatric staff would decide which patients would be seen by the consultants.

Every mental institute should have full-time internists. The facilities should also be used for teaching purposes.

Mental institutes should be built near urban centers, preferably adjacent to a teaching hospital where residency programs and non-psychiatric medical services are available.

17. EDMONTON CENTRE PRESBYTERIAL UNITED CHURCH

Mental health services should be integrated into the general health scheme. Planning of mental health services should be in conjunction with planning of general hospitals; out-patient departments as well as psychiatric wards are required. Mental health services should become part of the program of existing health units and clinics.

Hospital insurance should cover hospitalization in the Provincial mental hospitals.

Staff salaries should be competitive and patient loads should be reduced.

Citizen and hospital boards for mental hospitals should be established.

Social service departments of mental hospitals should be expanded and staffed with qualified professionals to give service before, during and after hospitalization.

Every effort should be made to attract or retain desirable staff by providing adequate salaries, scholarships, sufficient clerical help, and the opportunity to use their skills and training in positions they will perceive as challenging and worthwhile.

Alberta Hospital, Oliver should be an active treatment hospital. Other facilities should be established for those who need treatment but do not require psychiatric services. Problems such as alcoholism, geriatrics, behavior problems, the socially inadequate, etc., should not be grouped together.

The transportation from Edmonton to Oliver should be improved. This would improve integration of the hospital and the community; also it would make the hospital more accessible to families, friends, and staff (including volunteers).

More time and money should be spent on research to determine the causes and treatment of mental illness.

18. EDMONTON SOCIAL PLANNING COUNCIL

In 1963 the Council made a study of child care institutions in Edmonton and reported serious deficiencies. In 1966 the Edmonton Welfare Council also conducted a study and reported its findings to the Premier in 1967. This brief represents a third attempt to make known needs of emotionally disturbed and retarded children, as limited to residential treatment facilities and services. By limiting the study they said, "in no way do we wish to imply that institutional treatment is preferable for all children."

Numbers of children involved are not known. Estimates suggested are 43,680 retarded people, 8,736 retarded children and youths (under 20), and 1,950 emotionally disturbed children and youths age 5-19, in Alberta. Another estimate made by the Council was 1,000 emotionally disturbed children in Edmonton alone by 1970.

The Council reported "there is not sufficient accommodation for the severely retarded or for emotionally disturbed youth between 15 and 20 years of age." Temporary care facilities were viewed as the greatest need.

They contended that there should be clear standards of operation for facilities housing both groups and withdrawal of financial assistance if standards are not met.

Their recommendations related to:

- a. Appointment of a professional advisory committee by the Government to: devise classifications of child care institutions according to their functions; develop standards for accreditation; devise methods of applying accreditation.
- b. Provision of capital and operating grants by the Government to permit necessary improvements in accredited private institutions.
- c. Development of short term placement for temporary relief of parents from "very demanding and wearing responsibilities."

- d. More facilities for the retarded and emotionally disturbed groups.
- e. Improved services (after care, day care, training) for both.
- f. Research on service needs.

19. L. ENDERS

Business Manager, Alberta Hospital, Edmonton

The objectives and policies of the Mental Health Division, Department of Health should be clearly set down. We require long-range objectives in order to deal with treatment, plant facilities, research, etc. It is very difficult to discharge responsibilities when we do not know what policies are in existence. These should be reviewed annually.

A research program should be established so that in future we may treat the cause of mental illness rather than the symptoms.

Mental health services should be decentralized by: placing the various mental hospitals under boards of governors; establishing a direct grant system to the hospital boards for operating and capital costs.

20. J. ERICKSON

Lethbridge

There should be an active contact with the Division of Alcoholism through the voluntary efforts of individuals familiar with alcoholism.

This contact should be assisted by the Division, e.g., providing information, lectures, referral to cooperating physicians, transportation to active treatment centers.

This service should be observed and appraised by the Division authorities for a period of one year as the basis for deciding upon the merit of establishing permanent facilities in this community (Lethbridge).

21. FAMILY SERVICE ASSOCIATION OF EDMONTON

Mental health must be defined to include the broadest possible spectrum of people, from those concerned about themselves, to people who require clinical treatment. The definition of mental health must take cognizance of the needs and resources of the total family as well as focusing on one individual.

Emphasis needs to be placed on the positive aspects of mental health. Increased services must be provided through "well settings" rather than through hospitals, particularly those removed geographically from urban centers.

An educational program should be developed to improve liaison between "professional workers" in the community, to increase use of resources available, to strengthen mental health and to increase the knowledge of how a person would contact an available service.

Homemaker services should be expanded. Outlying areas have limited or no homemaker services. This service is especially useful in providing care for children and geriatric cases.

Health science complexes (in major teaching hospitals) should have a central registry available to the community that would provide people with referrals to services outside the complex. This would prevent wasted effort and duplication of service for an individual person.

Family agencies' use of counsellors, probation officers and psychiatric services should be integrated to allow for the strengthening of the mental health of the family unit.

Indian persons need special services to assist in developing a positive attitude about the communities in which they live.

Family agencies should be funded so they can serve an increased geographic area (e.g., not just metropolitan areas), through travelling clinics that would provide not only diagnosis but give treatment and rehabilitation service to surrounding and outlying communities.

More trained workers (e.g., social workers) are required. Their training should be integrated and unified. The licensing of workers and setting of the standards of qualification by professional groups must receive priority from the professional groups concerned. However, it is necessary to have the support of the Government in order to enact this legislation.

More and more emphasis needs to be placed on services, training of staff and research. The Government should be encouraged to consider the extension of financing to an increased number of voluntary agencies. The geographic areas served by the family agencies should be extended through a broadened base of financing by the Provincial Government.

22. MR. GEOFFREY A. FRETWELL

Lacombe, Alberta

As a private, deeply concerned citizen Mr. Fretwell deplored what he perceived as an "overall lack of care in respect to mental patients; also a general lack of personnel and facilities" to provide adequate care. He outlined three major tasks: the training and recruitment of more mental health professional workers; building small up-to-date hospitals at strategic locations, decentralized treatment and use of existing general

hospitals; and the immediate introduction of a "long range plan of rehabilitation including half-way houses and sheltered workshops."

Quoting from an annual report of the Board of Visitors, he illustrated the lack of personnel with such evidence as: "a shortage of forty registered nurses and forty psychiatric nurses" at Alberta Hospital, Ponoka; "no psychologist or psychiatrist" at the Guidance Clinic at Medicine Hat; only one psychiatrist in the Red Deer region to handle "a work load for at least three men." He concluded: "The same lack of qualified workers on every level can be noted at every location and every situation."

He pointed to severe overcrowding at Ponoka and Oliver, largely without air-conditioning, with mixed patient populations of "the criminally insane, alcoholics, senile old people, young people and even children." His judgment was that "the shock to the dignity of the human personality" is such that the hospitals constitute "a major obstacle to any recovery of a mental patient" and "a disgrace" to Alberta. He urged: smaller, well staffed, regional hospitals; segregation of patients by treatment groups; establishment of "psychiatric wings" at other hospitals, and outpatient services there, particularly for children, to avoid separation from home.

Other recommendations included: complete revision of the mental health Act to stress treatment and rehabilitation not "forcible detention and custody;" avoidance of uniformed police and marked cars where commitment is necessary; the appointment of chaplains to mental hospitals; paid work within hospitals for mental patients; rewards for good conduct but "never demerits or withdrawal of privileges for misconduct, which is now the case;" new, well-qualified, well paid appointees as Director of the Division and superintendents; inclusion of mental health in all its aspects under the Alberta Health Plan and M.S.I.; mandatory follow-up care for every mental patient for at least one year after release from hospital; pre-release training for "gainful employment" for young patients and the use of half-way houses and sheltered workshops for rehabilitation.

In addition, he proposed that monthly progress reports on every patient, signed by a qualified psychiatrist, be required.

Mr. Fretwell stated that the need for an adequate, expanded mental health program in Alberta is immediate and urgent. He said mental health should have top priority because of long delay in making changes and concluded: "The concern and motivation for improved mental health must come from the top level of the Department of Health in Alberta. We believe that a lack of concern at this level is the basic cause of the deplorable state of our mental institutions in the Province of Alberta."

23. MRS. EVA FUJCZAK

Grande Centre, Alberta

We require more facilities to deal with the mentally ill. Money spent on jails would be more wisely spent on special schools.

Financial assistance in the form of grants, loans, etc., should be readily available for individuals seeking training in the mental health fields.

24. MRS. ELMA HANON

Mental illness and juvenile delinquency reflect a lack of an individual's ability to understand himself. To correct this, mature and understanding teachers should attempt to help each young student to understand himself, along with the provision of necessary basic learning. As he begins to understand himself, the teacher could guide him in his search to gain the knowledge required for the utilization of his abilities.

Group therapy is a practical remedy and should be used extensively in mental hospitals.

25. THE JOHN HOWARD SOCIETY OF ALBERTA

Forensic Services

This brief pointed to the need for research on sexual deviation and criminal pathology, on one hand, and application of research findings in "a preventive treatment program for disturbed and potentially dangerous persons." It urged the development of forensic services in Alberta to provide psychiatric consultation, diagnosis and treatment "for persons in the courts" and on probation; to provide a similar service to clinics, hospitals and for self-referred persons; to provide teaching and research opportunities relating to "causes, courses, and correctional treatment of sexual deviation and delinquent behavior."

Regional forensic clinics, with local, generally autonomous boards, and located "in conjunction with university facilities, were proposed. Travelling diagnostic teams would also be required to serve the correctional institutions. Such clinics were judged to be urgently required in Edmonton and Calgary and future needs were likely to emerge in Red Deer, Lethbridge and Medicine Hat.

A Forensic Services Director would be "attached to the Department of Health" with the "status of a Deputy Minister or next thereto." His functions would include: coordination of a phased development of the services; departmental liaison; consultation to clinics; direction of travelling teams. The brief described staffing requirements of the clinics and teams, generally maintaining a composite of psychiatrists-psychologists-social workers.

Possible financial approaches were outlined: direct subsidies from Government; or a subsidy augmented by fees for service from courts, self-referred individuals, public agencies, etc., research grants, and funds from cities and local governments.

It was noted in the brief that legislation permits the courts to use existing psychiatric facilities. However, it was submitted that the facilities must be increased and their use made mandatory, through legislation and financial support.

26. THE WILLIAM ROPER HULL HOME Mental Health and Children

This brief concentrated on the following topics: reality therapy and its application at the Hull Home; the qualifications and employment of child care workers in Alberta; and foster home placement.

The use of diagnostic labels in the juvenile treatment field was condemned. Some of the labels are "emotionally disturbed," "mentally ill," "socially deviant;" and a major objection to them is that they tend to excuse the behavior of the individual to himself and to others. As stated in the brief "The individual is almost led to believe that his behavior has resulted from external forces operating upon him and over which he has had no control." The criterion or "social gauge" for behaviors is one of responsibility; behavior is "socially responsible" if an individual is satisfying his needs while not "imperiling the attempts of others to satisfy their needs;" one is socially irresponsible if he satisfies his needs at the expense of others.

The above concept of personal responsibility is basic to reality therapy developed by Glasser. He is reported to contend that irresponsibility is a crucial element in all personality disturbances. Where it exists, it has to be replaced by learned, responsible behavior. At the Hull Home, "responsible" behavior is taught in this manner: members of the 8-12 year old group are reinforced (rewarded) with tokens when behavior judged by their "key person" to be "responsible" is observed; the tokens can be exchanged for candy, pop, TV time, visits into the community; small groups, in a cottage setting, are involved; no punishment is used; different age groups, in separate cottages engage in different work and are rewarded differently for desirable behavior; schooling and occupational therapy are both included and the reward approach extends throughout.

The second topic of the brief concerned child care workers. Inadequate standards of qualification are reported to have resulted in poorly qualified people being employed. As stated in the brief "almost all child caring centres in Alberta are being staffed with inexperienced people ... who have been brought into the Province from other centres across the country." It was also noted that child care workers here "have almost no professional status" and each centre goes its own way with treatment programs.

A standard program of training, leading to a widely recognized diploma, was recommended.

The third topic was foster home placement. It was noted that there is a great shortage of suitable and available homes, resulting in retention of children in treatment facilities much longer than necessary. No solution is evident so the authors of the brief proposed a study to find out how effective foster home placements might be increased. It would be designed to provide answers in these specific areas: the current extent of foster home placements; the bases for placement; degree of success; factors resulting in failures; how improvements might be made; alternatives to be considered.

The brief also proposed the creation of a "Child Welfare Board" to establish goals and priorities in child welfare and to facilitate communication between currently isolated groups.

27. INSTITUTIONAL SERVICE WORKERS (HOUSEKEEPING)

Alberta Hospital, Ponoka

Better working conditions are required by housekeeping staff. Some prior thought should be given concerning where equipment is to be stored, when new buildings are being planned.

Wages should be improved.

28. C. W. IRVINE

Edmonton, Alberta

Among the basic health facilities required are nurseries for children with mental problems.

Diagnostic observation should be possible under play conditions. A clinical atmosphere tends to create experiences which could compound mental problems.

Special homes and schools should be provided on a "day basis."

Residential, institutional facilities should be provided for children requiring custodial care: village-like institutions; spacious open grounds; green lawns, etc., located in rural settings near larger urban areas.

Psychiatrists should visit patients when they are committed to a mental institution.

Mental health care in this Province requires some sort of coordination. Parents should not have to go from "pillar to post" seeking help for their children.

29. MRS. MIRIAM MANDEL

Edmonton, Alberta

The public should be educated as to what mental illness is and what can be done about it. This program of education should be conducted both outside and in the institutions for the mentally ill.

There should be a trend away from the existence of huge institutions. Small, home-like units with much interaction with the community should be developed.

Half-way houses, out-patient clinics, and continuing treatment for discharged patients should be established.

All employees of mental institutions should be required to undergo a kind of therapeutic orientation. The object would be to have each person aware of his own motives and avoid confusing his own problems with the problems of his patients. Many people are in the helping professions simply because of their own problems.

Each mental institution should be enabled to provide legal service for patients.

30. NATIONAL COUNCIL OF JEWISH WOMEN, CALGARY

Comprehensive mental health services should be provided in all regions of the Province. Out-patient clinics should be established.

The following additional services should be established: forensic clinics for the evaluation of offenders; day care centers; half-way houses; sheltered workshops; facilities for emotionally disturbed children.

31. NATIONAL COUNCIL OF JEWISH WOMEN, EDMONTON

Clinics and hospitals for the mentally ill are not adequate, either in terms of diagnosis or treatment. This situation should be remedied.

32. PARENT-SCHOOL ORGANIZATION, ALBERTA SCHOOL HOSPITAL, RED DEER Edmonton Committee

An institution similar to the Alberta School Hospital in Red Deer should be built in the greater Edmonton area to relieve the very long waiting list of the Alberta School Hospital.

Some adjustments should be made in the labour union laws which would enable "graduates" of the ASH to be employed.

Half-way houses should be established for children from the School who are working in the community; the children must return to the School at night, because no other accommodation exists, so the admission of new children is hindered.

We see no reason why people working in the mental health field should not be as highly regarded and paid as those working in other fields.

Very small children do not appear to have the attention of a matron or a house-mother on their wards. The presence of female staff on wards, now staffed by males, would do much to create a "homey" atmosphere.

Trainees from the Alberta School Hospital should be given an opportunity to participate in the advantages and training of the sheltered workshop located near St. Albert. It appears that candidates for it will be drawn from the Winnifred School for Retarded Children.

33. PATIENTS' COUNCIL, ALBERTA HOSPITAL, PONOKA

Governing of persons under the jurisdiction of the Lieutenant Governor and Attorney General, should be left to the discretion of the Medical Superintendent of the Hospital.

Special accommodation should be available at Ponoka for persons serving prison terms.

Adequate staffing and facilities should be supplied there through modernization of existing buildings; new buildings; a chapel; gymnasium; TV and radio in each ward; qualified teachers; improved social service facilities; Canada Manpower representation.

Mental patients should be reimbursed for their industrial services.

As many wards as possible throughout the Ponoka Hospital should be opened.

34. DR. STANLEY A. PERKINS

University of Lethbridge

Gifted Children

A policy of early school admission should be implemented which will allow gifted children, who are so evaluated by a licensed psychologist, to be admitted to school before the regular age.

School systems should be encouraged to implement a policy of identifying the gifted by use of standardized tests and teacher observations.

Programs for the gifted should be established, particularly at the elementary level. Acceleration and enrichment should be encouraged. The encouragement of such classes will require a person in the Department of Education solely responsible for the subject.

The Government should legislate and earmark special funds specifically for the use of gifted children and for training their teachers.

To assist with programs for the gifted, the schools need the services of qualified and competent counsellors.

Mental Retardation

The Province needs a comprehensive program for mental retardation articulated by levels and geographical areas. Programs and facilities are required in the areas of: (1) prevention, diagnosis, and treatment of mental retardation; (2) education, training and employment of mentally

retarded; (3) development and coordination of placement facilities; (4) laws and legislative action. Regional and zone committees should be established to study local problems. A director of mental retardation should be established to be responsible for implementing a comprehensive mental retardation plan.

The trainable mentally retarded programs now operated in Alberta by the Alberta Association of Mentally Retarded should be made the responsibility of the local school boards.

Legislation should be implemented which would permit mentally retarded students to remain in school until 21 years of age. Emphasis must be placed on providing work experience programs for the retarded.

School districts should be required to appoint a coordinator of special education.

All services to the retarded must be planned on a life-span basis.

Financial education must be provided for the education of special teachers for the retarded.

The Government must set an example by employing the retarded. More extensive manpower training programs are needed.

Immediate attention should be given to the early detection of retardation. Urgent steps must be taken to relieve the shortage of personnel to identify and assess mental retardation.

Institutional care of the profoundly and severely retarded must be decentralized.

Steps should be taken to ameliorate the conditions of culturally and economically deprived families.

All professions (nurses, doctors, teachers, etc.) dealing with the retarded should receive special training.

The curriculum in public schools must be more realistically adjusted to meet the needs of the "dull normal" or "slow learner."

Kindergartens should be established as part of the public school system.

Constructive professional counselling should be available at various stages in the child's life.

Counselling in Public Schools

A thorough study of the extent, nature and quality of the present guidance services in the Province should be made. Specialized skills are required to perform the guidance function adequately. These services should be withheld until suitable personnel are available. At all levels, persons assigned to counselling services should be rigidly selected as to personality, preparation and interest. As qualified personnel become available, all school systems, rural and urban, should initiate or extend guidance and counselling services.

Special certification should be implemented by the Department of Education for all counsellors and other pupil personnel workers. Financial assistance should be supplied for secondary and elementary counsellors taking counsellor education.

All principals should be required to take a course in guidance and counselling.

Special efforts should be made to place counsellors in elementary schools.

School counsellors should be appointed as full-time counsellors and not as teacher-counsellors.

35. MRS. M. POOLE

Edmonton, Alberta

Both by training and inclination, the psychiatrist is quite unprepared to treat either the acute stage of poisoning or the chronic effects of it. The solution of this problem would be to leave the treatment of these cases in the hands of more qualified professionals, e.g., a poison control center.

A properly constitute board should be set up by the Department of Health to hear appeals of citizens wrongfully detained in our mental hospitals.

36. PSYCHIATRIC AND EDUCATIONAL CENTRE VOLUNTEERS

Calgary

Some provisions should be made for the training and reimbursement of coordinators of such volunteer groups.

Immediate steps should be taken to use the facilities of the Psychiatric and Educational Centre to institute an adequate staff-training program, to include nurses, nurses aides and therapists. Use should be made of professional people involved with emotionally disturbed children. At the present time these people, due to lack of facilities and opportunity, function only in a service capacity to the community. They should be in a position to also teach, train, and carry out research.

The Human Resources Development Authority should be approached to set up bursaries or scholarships for people interested in taking training in preparation for work with emotionally disturbed children.

37. PSYCHIATRIC SOCIAL WORK DEPARTMENT, ALBERTA GUIDANCE CLINIC

Edmonton

Every effort should be made to obtain qualified and experienced staff for Guidance Clinics. Salaries should be competitive with other provinces and services. Benefits, such as educational leaves, research leaves, and staff exchanges should be offered.

Supervision and continuing education should be carried out by qualified supervisors interested in such work. A need exists for a professionally trained group worker, not only to set up and run group therapy but also to train and supervise other workers in group work techniques.

Social workers, as specialists in community organization should provide a preventive mental health service to the community, e.g., parents could join a counsellor in short-term discussion groups within elementary schools. Topics could incorporate child management, normal child development, etc. A public education coordinator with the Guidance Clinic could help in this area.

Time, money and a qualified researcher should be provided to evaluate existing clinic programs and methods of treatment and to do basic research.

Follow-up services should be provided by the Guidance Clinic, e.g., an automatic six-month or one-year follow-up on every case.

A possible alternative to the present difficulties with rural travelling clinics (inadequate services to rural areas and a strain on Edmonton clinic) would be the establishment of a permanent travelling team. This team, consisting of psychologists, social workers, and a consulting psychiatrist, could be responsible for all out-of-town referrals. This team would work closely with the health units and other community resources. Public education in rural areas would also be a responsibility of this team.

The above arrangement would eventually and hopefully evolve into permanent centers in the geographical areas administered by health units. Services offered by these centers should be quite broad and should include diagnosis, consultation, and treatment. Psychologists, social workers and, where possible, psychiatrists should staff these centers. Community organization and involvement would be a responsibility of the centers. In order to prevent professional isolation, staff members should be offered regular opportunities to attend institutes and conferences in larger urban centers. Extra compensation may have to be considered.

38. DR. CARL J. REICH
Calgary, Alberta

Dr. Reich notes a complex physical change, attributable by him to the stress of living, inadequate sunshine and minerals in diets, and which he terms "chronic maladaptation." Some manifestations, such as "emotional asthma," "chronic dermatitis" and "eczema" require in his view "a definite assessment of the particular aspects of the patients' physical environment during their lifetime, which may have influenced their chemical make-up and reaction of tissues."

39. MR. A. SHAW
Calgary, Alberta

Agencies responsible for staffing the proposed children's facilities in Calgary should arrange to institute a cooperative arrangement with the Alberta School Hospital in Red Deer and make full use of the valuable

experience and techniques of that institution.

Officials in charge of new Calgary facilities should recognize the necessity of providing continuing care for those children who seem incapable of responding favorably to treatment.

A well designed survey of the extent of the autistic problem and the interrelationship of background conditions and behavioral patterns, should be undertaken, to make possible long-term planning of treatment programs.

40. SOCIAL SERVICE DEPARTMENT, ALBERTA HOSPITAL, PONOKA

Encouragement should be given to decentralizing treatment centers in the mental health field.

More decision-making authority should be granted local mental hospitals in the management of patients' affairs, e.g., approval of the purchase of glasses, teeth, shampoo, etc., should be in the hands of the hospitals and not the head office in Edmonton.

Patients who work in hospital services should be paid.

More social workers are required by this department. An active recruitment campaign should begin immediately. Staff should be encouraged to attend continuing education programs. Financial assistance should be provided to staff to attend workshops.

A fully qualified teacher is required to set up educational programs both for the adolescents and adults within the hospital.

Future construction should be directed to the use of smaller units.

Community facilities should be developed and expanded. A Guidance Clinic should be established in Ponoka; the Alberta Hospital's out-patient clinic in Calgary should be expanded and adequately staffed; half-way houses should be established; Government assistance is required to finance advertising to expand the foster home program; industrial therapy projects within the Hospital and in the community are required; a significant expansion in the nursing home program is required.

41. SOCIAL SERVICE DEPARTMENT, CITY OF CALGARY

Mr. T. DeVries

This brief is concerned with "post hospital mental patients" and their participation in "community" social and recreational activities.

The emphasis of C.M.H.A. in such cases should be to provide a relatively short period of time for "treatment," i.e., there should be a

continuous "turnover" of members, with emphasis on increasing participation in community-based social and recreational programs.

There is a need for a more effective liaison between Ponoka Hospital, local hospitals and various community organizations, including C.M.H.A.

The social service agencies, public and private, can assist in identifying persons who may need the benefit of normal social and recreational activities.

A more active "reaching out" program (public education) needs to be instituted by existing agencies or organizations to ensure that all members of the community have the opportunity of participating in the desired activity.

A more active utilization of laymen and volunteers is required.

42. SOCIAL SERVICE DEPARTMENT, EDMONTON

Some satisfactory care arrangements should be made for the children of parents who are patients in hospitals. Frequently these children are neglected while parents are hospitalized. Again the importance of treating the family and not just the individual is seen.

The helping professions should realize that changes and dislocations in society have brought about corresponding disruptions in the family structure. There is an increasing number of one-parent families and an increasing number of working mothers due to economic necessity; our modern educational system prepares women for academic and professional pursuits rather than a career in the home, thus an increasing number of mothers enter the labor market in response to psychological and social motivation; adequate day care facilities do not exist for children of working mothers.

Adequate day care services are required primarily to meet the needs of children whose mothers are employed during the day. The majority of these children are physically and emotionally healthy with their only need being adequate substitute care. The absence of such care could result in mental and emotional damage. Day care may also help in the following situations: where a mother is admitted to hospital; borderline cases of neglect where removal of the child from the home may be the less adequate alternative; vulnerable situations where placement in a day care center is preferable to having the child institutionalized; day care may also help with children of immigrant families whose parents speak little or poor English and whose cultural patterns differ from the community's.

Mental hospitals in Alberta would be much more functional and free from many of their problems if they were not used as dumping grounds for all other social problems, e.g., geriatric cases, T.B. cases, alcoholics, behavioral problems and the socially inadequate.

In order to keep and train quality staff the Department of Health must become more flexible in its salaries and more competitive with similar community agencies.

After-care and supportive services need to be greatly expanded in the community.

43. MRS. T. ELAINE THOMAS

The public must be educated about mental illness. It is of utmost importance that they receive accurate information.

Psychiatric units should be part of general hospitals except in the case of long-term patients. The criminally insane should have special maximum security institutions; never should they be mixed with other mentally sick people. The public must be made willing to seek treatment in the early stages of illness.

Teachers should receive adequate training in the area of mental health, e.g., detection of early symptoms. Prevention of mental illness in teachers is also important through adequate training programs, good management and communication between administration and teachers. Teachers should be aware of ways to help prevent mental illness in their students. They should consider all fields of achievement worthwhile; discipline should be firm and reasonable; care should be taken in assigning grades to students.

Positive values of religion should be stressed in avoiding or preventing mental illness. A healthy home atmosphere is necessary for the prevention of mental illness. People should also be encouraged to assign high value to work.

44. DR. A. D. TOMPKINS

Vulcan Clinic, Alberta

There should be two centrally placed psychiatric units in the Province, perhaps one in Calgary and one in Edmonton, either affiliated with a general hospital or as separate units. These psychiatric units would admit psychiatric cases for observation, short-term therapy, arrange transfer to a mental hospital, and provide out-patient care and follow-up. Reports should be sent to the family doctor, so he could assist in helping the patient.

A regulation should be brought into force whereby a family doctor, on the completion of a committal form, would make it mandatory for a patient to be taken to a psychiatric unit for a short period of observation. The psychiatrist in charge would then decide whether the patient required short-term therapy at the unit or admission to a mental hospital for more prolonged treatment.

There should be a well trained student counsellor in every school district whose sole job is student counselling and he should be the liaison officer between the student, teachers, parents, family doctor, and the psychiatrist.

45. MR. J. VIRAVEC

Lethbridge, Alberta

Mr. Viravec contends that schizophrenia is a disease with discoverable physical causes; it is an organic rather than a functional disorder. He reported that some studies showed that this illness responds favorably to the administration of niacin, nicotinic acid or nicotinamide, when administered in large doses.

46. MR. D. WATERS

Calgary, Alberta

There is a link between good physical condition and good mental health. He recommends a number of exercises which have been of benefit to him and which might be of more general interest, e.g., proper breathing, walking, striving for erect posture.

CONFIDENTIAL BRIEFS

Acknowledgment is due to many other individuals who submitted confidential briefs or letters to the Study. Many of these were from former patients of Alberta mental hospitals and institutions or from relatives of patients or former patients. Several briefs were received from parents of children with educational or emotional problems. Some were reasonably satisfied with the work being done in the mental health field. Many, however, from their actual experiences, pointed out inadequacies in the mental health program of the Province. Frequently, recommendations were made for more residential services, halfway houses, treatment facilities for children and adolescents, more qualified staff and further research.

To preserve confidentiality, their briefs are not included in this report. The authors are sincerely thanked for their submissions and may be assured that they were read and the recommendations were given full consideration in the preparation of Volume I in 1969.

W.R.N.B.

PROGRESS AND PROBLEMS

Progress

The Alberta Mental Health Study revealed serious deficiencies in mental health services in the Province. The report on the Study (Volume I of Mental Health in Alberta) proposed major changes in concepts, policies, programs and organization. The Government of the day approved the report in principle and it received strong support from the Official Opposition.

It was also supported by a number of influential and concerned associations, including the Alberta Medical Association, the Alberta College of Family Physicians, the Alberta Psychiatric Association, the Alberta Association of Registered Nurses, the Alberta Hospital Association and the Alberta Branch of the Canadian Mental Health Association, among others. Press coverage throughout the study was remarkably informed and thorough and the major newspapers came out promptly and forcefully with editorial and other endorsement of the philosophy of the report and its major recommendations. Implementation of the report has received similar treatment consistently since 1969.

Under a new Minister of Health, the Honourable J. D. Henderson, some of the primary recommendations began to receive attention in 1969, the year the report was received by the Government.

The plan to construct a community mental health center, which the Study members judged to be another mental hospital under a different name, was abandoned. The development of general hospitals, as the major hospital-treatment facility in the case of mental illness, was started. An order-in-council was handed down in 1970 making it mandatory that mental patients be admitted for treatment at general hospitals. The Government undertook to provide psychiatric beds at the hospitals and review panels.

The formation of regional councils and other coordinating mechanisms was encouraged by the new Minister through financial and organizational assistance. The Calgary and District Council was widely representative of the professions, facilities, associations and agencies concerned with mental health programs.

In recognition of the need for facilities for the treatment of emotionally disturbed children south of Red Deer, funds for Woods Christian Home, earlier an orphanage, were provided by the Government to develop it as a treatment center. A multi-disciplinary team, involving psychiatry, social work and psychology, was created and treatment of severely disturbed adolescents, transferred from general hospitals, was begun.

Patient populations at the two "active treatment" mental hospitals were reduced, slowly at first and then at an increasing rate as alternative accommodation was made available. The reduction, accomplished before the change of governments, amounted to more than one-quarter and the populations began to approach manageable size.

A largely autonomous Commission on Drug and Alcohol Abuse was created to assume responsibility for the development, direction and evaluation of programs. That approach was not recommended in the Report on the Alberta Mental Health Study which contended, to the contrary, that drug and alcohol abuse are mental health problems, which should not be assigned to separate divisions or other organizational entities. One of the recommendations in the report will make this point clear, "The abuse of alcohol and the abuse of drugs should be treated as one problem and an aspect of mental health, in the development of services for detection, diagnosis, treatment, rehabilitation, prevention and research." (Volume I, p. 277).

Notwithstanding the above reservation, the formation of the Commission is recorded here as "progress." It can be regarded as a step in the right direction. Drug and alcohol abuse were at least brought together as "one problem," although separated from other mental health problems organizationally. It could also be argued that abuse was widespread and of acute concern, possibly justifying separate action temporarily.

The Report on the Alberta Mental Health Study had stressed the need for coordination at Government level of health-related departments, particularly Health and Welfare but also Youth, Education and the Attorney General. It was stated:

"The preventive and rehabilitative efforts of the Departments of Health and Welfare, as an example, have a natural relationship but they require coordination, which is lacking now at every level. Welfare is moving into the areas of diagnosis and treatment, admittedly from their point of view, and the dangers must be apparent. Overlapping services with resultant waste of money and effort, competition for scarce professional staff and less than optimum efficiency are some of the pitfalls which should be avoided." (Volume I, p. 82).

The response of the Government, under Premier Harry Strom, was to combine two departments into the Department of Health and Social Development.

Research into mental health problems, reported to be an urgent need following the Study, began to receive attention under the same Government. During the years 1967 and 1968 the Director of the Division of Mental Health was provided with only \$10,000 for that kind of research (Volume I, p. 316). On July 1, 1970, the Alberta Human Behavior Research Unit was established by the University and the Alberta Human Resources Research

Council, with financial support from the Government. In its first full year of operations the Unit had a budget of \$100,000 and significant contributions to a neglected area of mental health appeared to be possible for the first time.

The Report (Volume I, p. 298) noted that "treatment methods, generally, within provincial mental health services, are simply behind the times." It was also stated (p. 305) that "the range of treatment, which should be available in Alberta today, would include improved use of drugs and comprehensive methods of milieu and behavior therapy and modification techniques, as indicated by empirical findings. Use of a complete repertoire of promising approaches to treatment, instead of the current restricted approach, should become an objective of the mental health program." In an effort to stimulate the introduction of newer treatment methods, the honorarium granted to the Director of the Alberta Mental Health Study was used to underwrite the first symposium on behavior modification in Alberta at Banff on April 3-5, 1969. Annual symposia since have dealt with behavioral programs for schools, clinics and special facilities. Evaluation of programs is the 1973 topic.

Another accomplishment is in the less tangible area of public education and the development of a better understanding of behavioral deviations and "mental illness." The Study, with its wide-scale citizen involvement, perhaps can be credited with giving fresh impetus to that development. Professional associations did their part, too, in its continuation by making the findings of the Study known widely at their annual and other meetings for at least a year following the submission of the Report. The press of Alberta again, however, must be recognized as having played a major part in the creation of a better understanding of the problems, which stand in the way of good mental health, and of necessary action to deal with those problems.

From the time the Study was announced until the findings were published, and beyond, the need for mental health reform was stressed by the present Premier, the Honourable Peter Lougheed. Although that subject was not an issue in the election of 1971, because both major parties supported reforms, Premier Lougheed made it one of his campaign promises. And, when elected, he acted on the promise. As reported by the Edmonton Journal (Saturday, May 13, 1972, p. 1) "sweeping changes in the treatment of mental illness" were introduced to the Legislature on May 12 in the form of a new Mental Health Act, 1972. Health and Social Development Minister Neil Crawford was quoted in the same issue as calling the Act "the first giant legislative step" in adopting the recommendations of the 1969 Blair Report, which in the Journal's words "called for massive reform and new techniques in the treatment of mental illness." Mr. Barry Swadron, a Toronto lawyer and legal consultant to the drafting committee, with similar experience as consultant to other governments, was quoted by the Journal (p. 7) as describing the new Act as "the pace-setter for North America" and some of its provisions as "revolutionary."

Time for all interested persons to study and, if necessary, to modify the Act was provided following its second reading and, in amended form, it was passed at the fall session and was given assent November 22, 1972.

The Act recognizes that prompt treatment can occur only at community level. That, in turn, demands the employment of a wider range of professional personnel, with a greater degree of responsibility for observation, care, treatment and control of persons admitted to treatment facilities. Accredited "therapists," under the Act, would have such responsibility and they would also have authority to initiate committal procedures. Eligible to be recognized as therapists, when properly licensed, will be: medical personnel, psychologists, social workers and nurses.

Also, in accordance with the decentralization of services and the delegation of operational control to communities, as recommended by the Alberta Mental Health Study, the Act provides for the establishment of regional mental health zones and regional mental health councils. It also provides for a Provincial Mental Health Advisory Council which should help to maintain the momentum of reforms and to extend them. Rights of patients are carefully protected throughout the Act.

Other notable changes in mental health services were reported by the Minister in an address delivered to delegates attending the annual meeting of the Alberta Medical Association in Edmonton, September 29, 1972. According to his press release at that date they include the following.

1. The allocation of \$1.2 million for the current fiscal year as a special fund for the development of mental health services.
2. Thirty-three staff positions were transferred from the mental hospitals' budget, for redeployment to guidance clinic programs and community care units (the additional funds amount to \$247,000).
3. Within the allocation noted in #1, above, are funds for: "training programs, research and analysis" (\$256,000); more than \$500,000 to provide "74 additional field treatment staff positions throughout the Province and their office space and equipment"; the "operation and development of a Home Care Program based at the Edmonton General Hospital and in the town of Ponoka - approximately \$135,000." In addition, grants have been made to the Alberta Mental Health Association, to conduct a program of public information, and to a Sheltered Workshop Program.
4. The role of Guidance Clinics has been expanded to provide "comprehensive services rather than continuing to restrict their services to the assessment and treatment of children."

"An additional Clinic will be developed in the Town of St. Paul," thus bringing needed services to the northeastern part of the Province "for the first time." The staffs of Guidance Clinics have been doubled.

5. The numbers of patients at the large mental hospitals at Ponoka and Oliver were reduced further during the past year to 649 and 728, respectively. (On April 30, 1968 the patients at the two hospitals numbered 1,006 and 1,135, so the reduction in 4 years has amounted to approximately 36%). The Minister noted that the development of specialized units and the integration of wards at the hospitals has been continued.

In reference to the impact of #1-4, above, on "previously underserved areas of the Province," the Minister said: "In Medicine Hat, for example, we have just appointed, with the cooperation of the Medicine Hat planning group, an experienced coordinator of mental health. He will shortly have a staff of ten. Contrast this with the Guidance Clinic of two years ago when only one person was on staff to serve the same population."

In his speech the Minister also dealt with the home care unit, which had been established in Edmonton, foster home care and forensic units. The home care unit initially is to accept patients from any referral source for follow-up by teams of psychiatrists, social workers, psychologists and nurses. A pilot project in foster home care, established in Edmonton, has proven promising and is being extended to other regions. Homes will be rated, for reimbursement, according to the level of care they will provide. Standards have been established and are to be enforced to ensure that the homes will not become another form of "back ward" in old mental hospitals. Two segregated and centralized, maximum security forensic units are being planned for Edmonton and Calgary, the latter intended for short term assessment of remand cases.

It is known that several other important reform actions have been undertaken. They are:

1. Responsibility for the care of the mentally retarded has been transferred from the Division of Mental Health and a separate service has been created.
2. An active program of recruitment of professional staff has begun.
3. A regional coordinator of mental health has been appointed at Red Deer.
4. A follow-up nursing service for patients released from mental hospitals has been started.

5. A nursing consultant to the Department will be engaged.
6. \$48,000 has been assigned to bursaries for specialist training in the mental health field.
7. Discussions have been initiated between the Alberta Association of Registered Nurses and the Psychiatric Nurses' Association of Alberta to plan training programs which are relevant to modern mental health services.
8. A psychiatric clinic has been introduced at Claresholm and will function there regularly. It has already resulted in transfers to active treatment facilities and eventual discharge to community life is the objective in such cases.
9. Communication with units of the Division, e.g. Guidance Clinics, has been made more effective by joint consultation on budget and planning.
10. Detoxification centers (in-hospital units) and recovery centers (non-hospital facilities for acutely intoxicated persons not requiring medical treatment) are being started in Calgary and Edmonton. Monies have been assigned for 1972-73 and 1973-74 for that purpose.

Comment

All of the ten measures listed above were the subjects of comments and recommendations in Volume I of Mental Health in Alberta.

In addition, all of the six items of progress taken from the Minister's speech of September 29, 1972, and referred to earlier in this Chapter, relate to recommendations in that Report.

The new Mental Health Act, 1972, relates to the recommended review of legislation to ensure that it would support the proposed concepts and the new delivery system. It sets the stage for other necessary reforms, such as the coordination of the many services, units and agencies at community level through regional councils. It opens the way to wider employment of psychologists, social workers and nurses, if properly qualified, in the mental health field. Through the protection it extends to "formal" patients, it helps remove mentally ill from second class citizenship.

The disposition of the heavy, special investment of \$1.2 million in mental health developments relates to the recommended decentralization of services and the strengthening of diagnostic, treatment and rehabilitation resources in communities. Of particular interest is the reinforcement and extension of the services of Alberta Guidance Clinics, but equally important is the start made on sheltered workshops, foster homes and home care services.

One other major recommendation has received attention through continued reductions in the patient populations at the mental hospitals at Oliver and Ponoka. The large reductions made by the previous Government have been followed by further reductions. The hospitals are gradually being shaped into specialized, regional institutions, which should become capable of providing truly active treatment and regional consultative services, instead of largely custodial care. The Report on the Alberta Mental Health Study proposed that kind of role for them.

It is also gratifying to note the adoption by the Government of the basic principles of the Report, which will be evident from the following quotations taken from the same speech of the Minister.

1. "Mental health services must be moved into the community. By this we mean the task of placing a new emphasis on community based services and reducing our present emphasis on large isolated facilities."
2. "The creation of a high quality mental health service. This will entail the attraction of skilled professionals, special training programs and the commitment of all staff to excellence in programming."
3. "We intend to place mental health services within easy reach of all those in need of help."
4. "Mental health services have to be developed as a comprehensive and integrated program. Programs will be designed to meet a wide range of needs and to pull together and utilize the many resources available within Alberta."
5. "Programs will be developed with a commitment to consultation with those involved in service delivery and designed to foster the participation of Alberta citizens."

Problems

Problems are largely in the form of "unfinished business," or recommendations which remain to be acted upon. The Minister is obviously quite aware of these because he said, of his Department's progress, in his September 29th speech: "These steps are a beginning." It is a significant and substantial beginning, however, and with plans which are underway, it offers encouragement that Alberta may soon attain a high standard in the field of mental health and in the delivery of mental health services.

Referring back to Chapter 3 (Medical Officers of Health) one encounters the first piece of "unfinished business." There would still appear to be a need for coordination of governmental services in health and health-related fields at community level. The regional coordinators

and councils may bring it about. Some other form of organizational and physical integration, however, may still be necessary to get the maximum benefit from the costly services.

A second problem relates to the regulations which will provide for the implementation of the new Mental Health Act. It is a boldly innovative Act but implementation could founder if two important sets of regulations can not be created and applied. The first concerns the licensing of therapists, where it will be necessary to deal with confusion and disagreement about the roles of professional personnel, the need to depart from the restrictive and inadequate disease model of mental illness, and the need to ensure that low quality services will not result from wider participation in the provision of those services. The second relates to the determination of the functions of regional coordinators and regional coordinating councils. In that case, cooperation of agencies, facilities and personnel is involved and the surrender of some sovereignty in the greater interest of the community as a whole will have to be negotiated. Both sets of regulations present sensitive and difficult problems, which the passage of an Act alone does not solve.

A third problem is organizational in nature. The Department has been enlarged by the combination of Health and Welfare. There is little outward indication, however, that structure or methods of operation have changed. Mental health, alcoholism and drug abuse, health units, welfare units, the Health and Welfare Department and departments with related concerns, still appear to be walled off from one another organizationally and functionally.

There was no mention of Pupil Personnel Services in the Minister's progress report. They would be a logical focus for improvement soon. Guidance Clinics, expanded and strategically located, as planned, can meet many of the needs temporarily but, in the long term, services in the school system should be improved, particularly in areas outside the two large cities. Early detection and prompt treatment of problems at that level can often prevent the development of more serious problems and the waste of human talent later. Development of pupil personnel services in the school systems will also permit the use of another model, an alternative to the mental illness model, in an entirely appropriate setting.

Facilities and services for emotionally disturbed children, particularly in the south of the Province, still require attention and the same is true in the case of neurologically and intellectually handicapped persons generally. There does not appear to have been much action in that regard. However, a committee has been formed by the Department to consider mental health services for children. Moreover, as recorded above, attention has been given to the departmental organization responsible for the mentally retarded.

Research was mentioned by the Minister on September 29 but in the context of "training programs, research and analysis." It is not clear

how the \$256,000 assigned to those three items will be divided or how research monies will be spent. The Alberta Human Behavior Research Unit, which was started at Calgary in 1970, under the joint sponsorship of the University and Alberta's Human Resources Research Council, disappeared when the Council was disbanded by the present Government.

The aim of the Unit was to stimulate and coordinate a province-wide program of research on mental health, delinquent behavior, family life and aging. The following general areas of investigation were identified: the incidence and treatment implications of mental illness and maladaptive behavior; the trial and development of new methods of treatment and rehabilitation; the development of information resources relating to mental health aspects of aging, including the effects of urbanization; community services for the treatment and rehabilitation of the mentally ill and socially deviant; preventive mental health measures; delinquency prediction and control; evaluation of behavior modification methods of treatment and training.

All of the above areas still require research. Current scientific knowledge is simply not sufficient to provide a strong foundation for mental health programs, although much better use could be made of existing knowledge. Programs, which consist only of service, soon become stagnant and ineffective without the critical atmosphere, the constant stimulation of new ideas and knowledge, which come from related research, including basic research, short term and evaluative or operational studies. The extremely hopeful "beginning," outlined by the Minister and described above, is unlikely to develop into a high-quality mental health program if research is set aside or given a low priority. The Province followed that course until 1970 and the results were disastrous.

The Alberta Mental Health Study, itself, left the Government with a major piece of unfinished business, the definition of the relative roles of professional personnel in the field of mental health. The task group, which studied the subject, reported that the whole mental health field is in a state of flux and each discipline is in the process of trying to define its role. The briefs reported in this Volume from physicians, psychologists, social workers and nurses reflect both uncertainty and disagreement. The task group seemed optimistic, however, that a resolution of the role problem would probably emerge through working together, experimenting and participating in a dialogue. They concluded that the current fluid situation is healthy because it offers opportunity for change and improvement.

The situation may be healthy in that sense but it is virtually untenable when necessary preparation for employment is considered. The Department of Health and Social Development is trying to determine what preparation is necessary for nurses in mental health services. Briefs from the Alberta Association of Registered Nurses and the Psychiatric Nurses Association of Alberta, in Chapter 5, indicate that the two groups

are quite a distance apart in their thinking, although there are common grounds for a working agreement. The Department is to be commended for bringing representatives together to develop training programs which will be more relevant to modern mental health services.

The problem will not be solved even if some agreement is reached regarding nurses. Psychologists, psychiatrists, family physicians and social workers will have to work through their differences, too, particularly with respect to treatment. Each engages in therapy and it is difficult to distinguish one from the other, without some formal identification. There is a need for an operational definition of roles in relation to the objectives, which can be achieved from the work of each kind of specialist. Given that kind of definition, it would then be possible to plan minimum training requirements in a rational manner. The unique and common contributions of each specialty have to be clarified so it will be possible to decide who should be doing what. Moreover, critical objectives of treatment and rehabilitation must be identified if education, training and practical experience of trainees are not to be wasted.

The licensing of therapists under the new Act will require the determination of standards. That determination will dictate an examination and a definition of critical outcomes, unique and common contributions of specialties and professional roles in detail. The Government has indicated, in the case of nurses, that it will assume leadership in obtaining the role information necessary to operate services successfully. The result could be the introduction of order and reason into the confused settings of professional preparation and employment in the field of mental health.

Dr. K. I. Pearce and the Study Group on Relative Roles of Professional Personnel, in 1968, proposed one or two institutes should be formed, with university affiliation, to permit medical, psychological and social welfare personnel to work toward a definition of their respective roles in mental health services. An institute was seen as a means of experimenting with the provision of different types of service to different segments of the population. It would engage in research, teaching and the provision of service, much of it extramural in the communities within its reach. The development of Woods Christian Home, the Vocational Research and Rehabilitation Institute and the Human Behavior Research Unit at the University of Calgary seemed to offer an opportunity to explore the idea but the disbandment of the Unit did not help. The problem of roles in relation to preparatory education, training and experience is still present. It is considered essential to obtain at least interim, working solutions, in order to plan training and employment. These solutions can be modified, of course, over the long term through experimentation and experience, but they are needed now.

It is interesting to note the small amount of money (\$46,000) assigned to bursaries for specialist training in the mental health field. That amount is only a small fraction of the money required annually, if any significant progress is to be made in developing specialized manpower for mental health. The requirements in terms of necessary education and training must be determined, of course, and, when that has been done, much more financial support should be provided. (See Volume I, p. 85-114; 117-138; and 316).

Another action taken by the Government, in 1972, was to repeal the Sexual Sterilization Act, which had been in force in one form or another since 1928. It was viewed as possibly infringing on human rights, especially in borderline cases. The Report on the Mental Health Study (Volume I, p. 267) did not recommend that the Act be set aside but it did recommend the introduction of more safeguards (e.g. the appointment of a human geneticist to the Eugenics Board; complete professional documentation in presentations to the Board). Society's responsibilities, in the case of the likely production of defective progeny, remain to be enunciated.

Decentralization of services and of operational authority to regions and communities and their integration in a comprehensive delivery system were central themes of Volume I of Mental Health in Alberta, 1969. The progress described above indicates that the Government supports those concepts and is acting to apply them. It is one thing to turn over services and operational authority to communities; it is quite another matter to make the system work. As cautioned by Dr. R. O. Jones, a consultant to the Study in 1968, regionalization does not in itself constitute a guarantee that the resulting system will work well. Local boards, regional coordinators and councils can probably be effective if they are granted sufficient community and professional support. At the moment, it can not be said that the experiment will be a success. It can be said, however, that the evolving system is taking the form demanded by communities and associations during the Alberta Mental Health Study.

Closely related to the matter of community acceptance of responsibility is the subject of priorities. When the Mental Health Act, 1972 was introduced in the Legislature, Premier Lougheed made it clear that mental health was being assigned a high priority. He reminded members that every constituency's pet project can not have that priority. It remains to be seen whether the positive public response, followed by governmental action, toward reforms in mental health services, will be sustained until those reforms have been achieved.

The final recommendation of the Report on the Alberta Mental Health Study was that there should be a full-scale review of action taken on the Report, results of such action and the "need for further change or development in Alberta's mental health services in three years' time (1972)." (Volume I, Mental Health in Alberta, p. 338). This Chapter has been

prepared to meet that requirement to a modest extent. It has several limitations. One is that it is not a full-scale review but is based on reports of progress instead of on-the-spot examination. The second is that the author also prepared the first report and can not be regarded as an unbiased evaluator. However, facts have been separated from opinion and they are sufficient to indicate, without question, that mental health reforms are underway to a very significant extent. Much has been achieved since February 1969 and the energetic approach of the Government should yield even greater achievements in the next few years. The firm support and participation of communities and the cooperation and commitment of the professions would appear to be the only remaining prerequisites to success.

W. R. N. Blair

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to

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* Dr. Kotkas' name was omitted from p. 11, Volume I. He was a member of the Study Group on Relative Roles of Professional Personnel. His paper on "the psychiatrist" is summarized in Volume II. W.R.N.B.

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